MEDICARE BENEFIT IMPROVEMENTS ACT OF 1990

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

H.R. 3880

TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO IMPROVE MEDICARE BENEFITS WITH RESPECT TO HOSPICE CARE, SCREENING MAMMOGRAPHY, IN-HOME RESPITE CARE, AND HOME HEALTH SERVICES

FEBRUARY 27, 1990

Serial 101-76

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MEDICARE BENEFIT IMPROVEMENTS ACT OF 1990

TUESDAY, FEBRUARY 27, 1990

U.S. House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to call, at 2 p.m. in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing and a copy of the bill, H.R. 3880 follow:]

FOR IMMEDIATE RELEASE
THURSDAY, FEBRUARY 15, 1990

PRESS RELEASE #17
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON H.R. 3880, THE MEDICARE BENEFIT IMPROVEMENTS ACT OF 1990

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on H.R. 3880, The Medicare Benefit Improvements Act of 1990. The hearing will be held on Tuesday, February 27, 1990, beginning at 2:00 p.m., in the main Commmittee hearing room, 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The Medicare Catastrophic Coverage Act of 1988, repealed in November 1989, added a number of new benefits to the basic Medicare benefit package. These benefits included mammography screening, expansion of home health care and hospice services and in-home respite care. With P.L. 101-234, the Medicare Catastrophic Coverage Repeal Act of 1989, these benefits were eliminated.

The Medicare Benefit Improvements Act of 1990

On January 24, 1990, Chairman Stark, joined by Mr. Gradison (R., Ohio), Mr. Waxman (D., Calif.), Mr. Madigan (R., Ill.), and 49 original cosponsors introduced the Medicare Benefit Improvements Act of 1990.

This legislation would provide Medicare coverage for a limited set of benefits repealed by P.L. 101-234, including mammography screening, expanded home health and hospice services, and in-home respite care. The benefits would be financed by a modest increase in the Part B premium. According to the most recent estimates by the Congressional Budget Office, the Part B premium would be increased by $0.80 per month in 1991 to cover the cost of these benefits.

Mammography Screenings. Under current law, Medicare does not cover mammography screening -- a safe and reliable procedure used to detect tumors. The five year survival rate for breast cancer is nearly 100 percent when detected at an early stage. According to the American Cancer Society, the risk of developing breast cancer is highest among elderly women. In 1989, approximately 43,000 women died of breast cancer, the majority of whom were ages 55 and older. Medicare coverage would increase the probability of early detection by eliminating financial barriers to routine mammograms.

H.R. 3880 would provide Medicare coverage for mammography screening for aged and disabled Medicare beneficiaries. Medicare coverage for mammography screenings would cover biennial screenings for women ages 65 and older, a baseline screening for women between the ages of 35 and 40, biennial screening for women between ages 40 and 49, annual screenings for high risk women between the ages of 40 and 49 and all women between ages of 50 and 64.

Home Health. Medicare's home health benefit provides intermittent visits to eligible beneficiaries. The current interpretation of intermittent care limits the frequency of home health visits to no more than five days per week, for up to three consecutive weeks.

H.R. 3880 would allow individuals to receive daily services, defined to include up to seven days per week, for up to 38 days. Current guidelines that allow continuation of services under unusual circumstances would continue to be recognized.

In-Home Respite Care. The Medicare program does not currently provide coverage for in-home respite care. Respite care, defined to include the services of homemakers, home health aides, personal care aides and licensed nurses, provides relief to caregivers who attend to the needs of functionally impaired and chronically dependent beneficiaries.

H.R. 3880 would provide up to 80 hours of respite care services to chronically dependent homebound beneficiaries. Chronically dependent beneficiaries would be eligible to receive services if they (1) are dependent on a voluntary caregiver for assistance with at least two activities of daily living and (2) have out-of-pocket expenses that exceed the $1,780 Part B limit in 1991.

Hospice. Under current law, the Medicare hospice benefit is limited to a 210-day benefit period. H.R. 3880 would eliminate the 210-day limit if a beneficiary's physician or hospice director recertifies that the beneficiary is still terminally ill.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Wednesday, March 15, 1990 to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

I

101ST CONGRESS
2D SESSION

H. R. 3880

To amend title XVIII of the Social Security Act to improve medicare benefits with respect to hospice care, screening mammography, in-home respite care, and home health services.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 24, 1990

Mr. STARK (for himself, Mr. GRADISON, Mr. WAXMAN, Mr. MADIGAN, Mr. COYNE, Mr. PICKLE, Mr. LEVIN of Michigan, Mr. MOODY, Mr. CARDIN, Mrs. JOHNSON of Connecticut, Mr. RANGEL, Mr. FORD of Tennessee, Mr. DOWNEY, Mr. ANTHONY, Mr. ANDREWS, Mr. MCGRATH, Mr. SCHEUER, Mr. WALGREN, Mr. SIKORSKI, Mr. BATES, Mrs. COLLINS, Mr. SYNAR, Mr. ACKERMAN, Mr. BOEHLERT, Mr. CONDIT, Mr. CROCKETT, Mr. DEFAZIO, Mr. DERRICK, Mr. DURBIN, Mr. FAUNTROY, Mr. GEJDENSON, Mr. GILMAN, Ms. KAPTUR, Mr. KILDEE, Mr. KOSTMAYER, Mr. LANTOS, Mr. LEHMAN of Florida, Mr. LEWIS of Georgia, Mr. MAVROULES, Mr. MCDERMOTT, Mr. MCNULTY, Mrs. MORELLA, Mr. NEAL of North Carolina, Ms. OAKAR, Ms. PELOSI, Mr. PENNY, Mr. REGULA, Mr. ROYBAL, Mrs. SAIKI, Ms. SLAUGHTER of New York, Mr. UDALL, Mr. VENTO, and Mr. WOLPE) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend title XVIII of the Social Security Act to improve medicare benefits with respect to hospice care, screening mammography, in-home respite care, and home health services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Benefit Improvements Act of 1990".

SEC. 2. MEDICARE COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as revived by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989 and as amended by the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) in subsection (s)—

(A) in paragraph (11), by striking all that follows "(bb))" and inserting a semicolon,

(B) in paragraph (12)(C), by striking all that follows "area)" and inserting "; and", and

(C) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (jj));"; and

(2) by inserting after subsection (ii) the following new subsection:

"Screening Mammography

"(jj) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.".

(b) PAYMENT AND COVERAGE.—Section 1834 of such Act (42 U.S.C. 1395m), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (c)(1)(A)" after "conversion factors", and

(2) by inserting after subsection (b) the following new subsection:

"(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

"(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

"(i) the actual charge for the screening,

"(ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or

"(iii) the limit established under paragraph (4) for the screening mammography.

"(2) FREQUENCY COVERED.—

"(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

"(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

"(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

"(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary),

payment may not be made under this part for a screening mammography performed within the 11 months of a previous screening mammography, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months after a previous screening mammography.

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months after a previous screening mammography.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months after a previous screening mammography.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically

the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1993.

"(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

"(4) LIMIT.—

"(A) $50, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1991, is $50, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1992, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

"(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between profes-

sional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1991, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or if less, as defined in subsection (b)(5)(B) or as defined in section 1848(g)(2)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—

"(i) in 1991, 125 percent of the limit established under paragraph (4),

"(ii) in 1992, 120 percent of the limit established under paragraph (4), or

"(iii) after 1992, 115 percent of the limit established under paragraph (4).

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 of such Act (42 U.S.C. 1395z), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by inserting "or whether screening mammography meets the standards established under section 1834(c)(3)," after "1832(a)(2)(F)(i),".

(2) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by inserting before the period the following: ", or whether screening mammography meets the standards established under section 1834(c)(3)".

(3) Section 1865(a) of such Act (42 U.S.C. 1395bb(a)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989,

is amended by inserting "1834(c)(3)," after "1832(a)(2)(F)(i),".

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) of such Act (42 U.S.C. 1395l(a)(2)(E)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by inserting ", but excluding screening mammography" after "imaging services".

(2) Section 1862(a) of such Act (42 U.S.C. 1395y(a)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of screening mammography, which is performed more frequently than is covered

under section 1834(c)(2) or which does not meet the standards established under section 1834(c)(3), and, in the case of screening pap smear, which is performed more frequently than is provided under section 1861(nn);''; and

(B) in paragraph (7), by inserting ''or under paragraph (1)(F)'' after ''(1)(B)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1991.

SEC. 3. IN-HOME RESPITE CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) of the Social Security Act (42 U.S.C. 1395k(a)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in paragraph (2)(A)—

(A) by inserting ''(i)'' after ''(A)'', and

(B) by inserting before the semicolon at the end the following: '', and (ii) in-home respite care for a chronically dependent individual for up to 80 hours in any 12-month period described in section 1861(kk)(4), but not to exceed 80 hours in any calendar year''; and

(2) by adding at the end the following new sentence:

"In the case of in-home respite care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME RESPITE CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x), as amended by section 2(a)(2) of this Act, is amended by inserting after subsection (jj) the following new subsection:

"In-Home Respite Care; Chronically Dependent Individual

"(kk)(1) The term 'in-home respite care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.

"(4)(A) The 12-month period described in this paragraph is the 1-year period beginning on the date that the Secretary determines that a chronically dependent individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (5)(A)) in an amount equal to the part B limit (as determined under paragraph (5)(B)) for the year.

"(B) In the case of an individual who qualifies under subparagraph (A) within 12 months after previously qualifying, the subsequent qualification shall begin a new 12-month period under this paragraph.

"(5) For purposes of this subsection:

"(A) The term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under part B, the amounts of expenses that the individual incurs that are attributable to—

"(i) the deductions established under section 1833(b), and

"(ii) the difference between the payment amount provided under part B and the payment amount that would be provided under part B if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in sections 1833(a), 1833(i)(2), 1834(c)(1)(C), 1835(b)(2), 1866(a)(2)(A), 1881(b)(2), and 1881(b)(3).

"(B)(i) The part B limit for 1991 is $1,780. The part B limit for any succeeding year shall be such an amount (rounded to the nearest multiple of $1) as the Secretary estimates, for that succeeding year, will reflect a level of out-of-pocket part B expenses that only 5.5 percent of the average number of individuals en-

rolled under part B (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) will equal or exceed in that succeeding year.

"(ii) Not later than September 1 of each year (beginning with 1991), the Secretary shall promulgate the part B limit under this subparagraph for the succeeding year.".

(c) PAYMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)), as restored by the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home respite care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home respite care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with re-

spect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.''.

(d) CERTIFICATION.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)), as restored by the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in subparagraph (E), by striking ''and'' at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) in the case of in-home respite care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.''.

(e) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 2(d)(2) of this Act, is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking ''and'' at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting ", and", and

(iii) by adding at the end the following new subparagraph:

"(G) in the case of in-home respite care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home respite care, as is otherwise permitted under paragraph (1)(G)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home respite care for chronically dependent individuals under the amendments made by this section.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1991.

SEC. 4. EXTENDING HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)), as restored by section

201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.".

(b) PAYMENT UNDER PART B.—Section 1833(d) of the Social Security Act (42 U.S.C. 1395l(d)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) by striking "(d) No payment" and inserting "(d)(1) Except as provided in paragraph (2), no payment"; and

(2) by adding at the end the following new paragraph:

"(2) In the case of home health services furnished to an individual enrolled under this part for which payment is made only as a result of the application of the last sentence of section 1861(m), payment shall be made under this part.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished in cases of initial

periods of home health services beginning on or after January 1, 1991.

SEC. 5. EXPANSION OF HOSPICE BENEFIT.

(a) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d), as restored by section 101(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989 and as amended by the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) in subsection (a)(4), by striking "90 days each" and all that follows through "with respect to" and inserting the following: "90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to"; and

(2) in subsection (d)—

(A) in paragraph (1), by striking "90 days each" and all that follows through "lifetime" and inserting the following: "90 days each, a subsequent period of 30 days, and a subsequent extension period during the individual's lifetime", and

(B) in paragraph (2)(B), by striking "a 90- or 30-day period," and inserting "a 90- or 30-day period or a subsequent extension period,".

(b) CONFORMING AMENDMENT.—Section 1814(a)(7)(A) of such Act (42 U.S.C. 1395f(a)(7)(A)), as restored by section

101(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii), by striking the semicolon at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to care and services furnished on or after January 1, 1991.

SEC. 6. FINANCING THROUGH INCREASE IN MEDICARE PART B PREMIUM.

(a) INCREASE IN PREMIUM.—Section 1839 of such Act (42 U.S.C. 1395r), as restored by section 202(a) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following new subsection:

"(g)(1) Except as provided in subsection (f), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased (for months occurring in 1991 through 1995) by the following additional premium or (for months after Decem-

ber 1995) by such an additional premium determined in accordance with paragraph (2):

"(A) For months in 1991, $.80.

"(B) For months in 1992, $1.00.

"(C) For months in 1993, $1.00.

"(D) For months in 1994, $1.20.

"(E) For months in 1995, $1.30.

"(2)(A) The Secretary shall, during September of 1995 and of each year thereafter, determine and promulgate the additional premium under this subsection for months in the succeeding year. Such premium amount shall be equal to the amount the Secretary estimates to be necessary so that the aggregate amount of premiums collected under this subsection for months in the year will equal the total of the benefits and administrative costs which the Secretary estimates will be payable in such year from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund that are attributable to the amendments made by the Medicare Benefit Improvements Act of 1990. In calculating such additional premium, the Secretary shall include an appropriate amount for a contingency margin, and shall adjust such premium to take into account the amounts by which the additional premiums established under this subsection with respect to months in any year are greater or less than the amounts required to pay for benefits paid and such

administrative costs incurred in such year that are attributable to the Medicare Benefit Improvements Act of 1990.

"(B) If any premium increase for a month under this paragraph is not a multiple of 10 cents, the Secretary shall round the increase to the nearest multiple of 10 cents.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1839 of such Act (42 U.S.C. 1395r), as restored by section 202(a) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in the second sentence of subsections (a)(1) and (a)(4), by inserting "(other than costs relating to the amendments made by the Medicare Benefit Improvements Act of 1990)" before the period;

(B) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(C) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(D) in subsection (b), by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsections (f) and (g))"; and

(E) in subsection (e)(1), by inserting "except as provided in subsection (g)," after "subsection (a)".

(2) Section 1844(a) of such Act (42 U.S.C. 1395w(a)), as restored by section 202(a) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to monthly premiums for months beginning with January 1991.

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Chairman STARK. We will consider H.R. 3880, the Medicare Benefit Improvements Act of 1990, a bill introduced by myself, Mr. Gradison, Mr. Waxman, Mr. Madigan, and 49 original cosponsors. As of today, 96 Members of Congress have cosponsored the bill.

The Medicare Benefit Improvements Act would provide Medicare coverage for mammography screening and in-home respite care, and would expand Medicare coverage for home health care and hospice benefits. These new benefits would be financed by a modest increase in the part B premium.

This bill was introduced early to restore these benefits at the earliest possible date.

These were benefits included in the Medicare Catastrophic Coverage Act, one of the most outstanding legislative achievements in Mr. Gradison's career. Unfortunately, the Catastrophic Act was repealed late last year. While we are all aware of the controversy that led to the demise of that program, there was little controversy over these four benefits.

First, H.R. 3880 would provide Medicare coverage for mammography screening for aged and disabled beneficiaries, and despite unambiguous gains from mammography screening, Medicare does not now cover this life-saving benefit.

Second, the bill would provide coverage for respite care, including the service of homemakers, home health aides, personal care aides and licensed nurses. The 80 hours would provide substantial relief to thousands of care-givers who attend to the needs of chronically dependent home-bound beneficiaries.

Third, the current home health benefit would be expanded to allow individuals to receive daily services, defined to include up to 7 days per week, for up to 38 days.

Fourth, the Medicare Benefit Improvements Act would eliminate the current 210-day limit on hospice care. It would provide that a beneficiary's physician or hospice director would recertify that this care is still needed because of terminal illness.

The proposed bill is designed to be budget neutral. The benefits would be fully funded by a small increase in the part B premium. According to the most recent CBO estimates, the first-year premium would be an additional 80 cents per month, increasing to $1.30 per month 5 years after the bill is enacted.

Today we have three panels. We are pleased to begin with testimony from our colleagues, Mrs. Boxer and Ms. Oakar. I have asked those witnesses to please come to the table. Before they begin, I would like to recognize Mr. Gradison.

Mr. GRADISON. I have no comments to make.

Chairman STARK. Are there any other members?

If not, it is my joyous duty to welcome Barbara Boxer and Mary Rose Oakar to the committee. You are both welcome. Please proceed in the order that you appear on the witness list, which happens to also be alphabetical. Barbara, I understand you do not have a prepared statement. So please, if you would like to proceed to enlighten us in any way you are comfortable, and I also understand you may have to dash on, so if any of the members have questions at the conclusion of Mrs. Boxer's testimony, please jump in.

Otherwise, please be excused whenever you have to go, and then we will recognize Mary Rose.

Mrs. BOXER. Mr. Chairman, because of the critical importance of this issue, I have decided to pass up going over to the White House to greet the San Francisco Forty-Niners, which was on my schedule. I want you to know that this issue is that important to me, and I would at this time——

Chairman STARK. Next year you can recognize the Oakland Raiders.

Mrs. BOXER. We will do that at the appropriate moment, but Mr. Chairman, I can now defer to Mary Rose Oakar. She has been such a leader on this, since the time pressure is off, if that is OK with you, I will defer to her to begin.

Chairman STARK. By all means. Mary Rose Oakar, we are pleased to have you here. Please proceed.

STATEMENT OF HON. MARY ROSE OAKAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. OAKAR. Thank you, Mr. Chairman, and distinguished members of this important subcommittee.

I would like to ask unanimous consent to submit my entire statement for the record, Mr. Chairman.

Chairman STARK. Without objection.

Ms. OAKAR. Mr. Chairman, I want to say at the outset that I support the bill that you and your distinguished minority leader and others have sponsored. I am one of the original cosponsors, if you will, and I want to congratulate you. Certainly the areas of respite care, expanded home health services, hospice care, et cetera, are very, very important, and you and I and Congressman Gradison have the distinction—I hope it is a distinction when we are finished with the report—of serving with each other on the Pepper Commission. And I hope that all these issues are going to be part of our report plus others.

Mr. Chairman, as you might imagine, however, I would like to zero in on an issue that you have had hearings on before and have been—and is an issue that I am especially concerned about, and that is the issue of breast cancer, Mr. Chairman.

Mr. Chairman, I think we are in a state of—and members of the committee, I think there is a crisis out there that has not really been addressed. As you know, we were able to get the mammography coverage slid in, the prevention aspect slid into the catastrophic bill, and then when catastrophic was repealed, that, unfortunately, went with it and we know that mammography coverage saves money and most importantly it saves lives.

I am reminded of the fact that one of our distinguished colleagues, as an example, just lost his wife in her 50's to breast cancer; in 1960 1 out of 20 women were diagnosed with breast cancer. In 1977, 1 out of 13; in 1989, 1 out of 10. Today it is 1 out of 9. It is the leading killer of women ages 35 to 54, and we feel that in the year, 2000, 51 percent of the women in this country will be in that age group, and it will be catastrophic. Think about this, gentlemen. Really think about this.

Approximately 143,000 women in the United States will be diagnosed with breast cancer this year. Forty-three thousand will die of breast cancer this year. Now, you know, in the 10-year Vietnam

war era, 57,000 men and women died in combat, and all of us lament any loss of lives in any type of warfare. But we have also felt somewhat ashamed that that happened and saddened by the death of those men and women.

In the same 10 years 300,000 American women died of breast cancer. One woman gets breast cancer or finds out about it every 13 minutes in this country. Now, I really feel the time has come for us to address this issue, and there are two areas of concern.

One is that the least we should do, I mean the bottom line least we should do is to have mammography coverage in Medicare and Medicaid. If we did that, you can be sure that the private insurance companies would follow. They tend, as you know, all of you are experts in health care in this committee, you know you deal with these issues every day of the week. So you can imagine that you would be saving so many lives, 4,000, from your statistics, Mr. Chairman, 4,000 people on Medicare, individuals who get breast cancer this year, and yet the issue is why haven't we done enough with prevention in this country.

I really don't think we have the will to do it, and it is up to this committee to do it. I am telling you, I worked on this issue for about 8 or 9 years. The Aging Committee has had countless hearings on it.

We have had First Ladies testify. Every First Lady with the exception of Barbara Bush, in the last five First Ladies have had a breast tumor or breast cancer. I mean, what more do we have to say to this Congress than to at least have mammography coverage in Medicare?

If we did that, we can be sure that ultimately the cost of mammograms in the private sector would go down. Probably they cost about $20 or so. Now they cost between $100 and $150. You say well, that is not much. Then why aren't more women getting a mammogram. It is not enough to say it that way because the average elderly woman in this country lives on $400 a month.

You cannot expect her—and that is what her Social Security check is. Only 20 percent of those women have any other source of income. You cannot expect her to be zealous to get a mammogram when it is going to take up one-fourth of her monthly income, source of income or more, and so it is incumbent upon you people. Honestly, you have such power to do something about it, to phone in right away.

If you did it tomorrow and we brought it to the Floor, I guarantee that it would pass practically unanimously. Now, shame on us in this Congress if we don't do it. I named my bill, which singles out the issue of mammography, after a woman named Rose Kushner, who had had breast cancer. She was a journalist, I believe, Ben, she was in or around your area.

She was originally from Baltimore, and she was heroic in calling attention to this dreaded disease, and she gave some of her own hours and time to this issue. One of the things she told me about was the prejudice that existed at NIH toward female-dominated diseases. I mean, we don't even have research on a case-by-case basis for breast cancer when 43,000 women a year die of it. And there are all these immunologists and all these scientists who

really want to zero in on this as an issue so that we finally get a vaccine to prevent it.

I mean, I am outraged. If I sound a little bit on the outrageous side today, let me tell you, I have had it with this issue because I feel that if we don't do something about it in this Congress, and that is why I am delighted that you are having this hearing, and that you have this aspect in your legislation. Then I think we should be totally ashamed of ourselves.

I honestly and truly believe that. In memory of people like Rose, who unselfishly gave of their time and energy and probably lost a few years because of the fact that they perhaps could have taken a little bit better care of themselves in sacrificing their lives for other people and other lives and other families, I just beg the members of this committee to pass out this legislation right away or at least immediately, full mammography coverage in Medicare.

We know that in terms of cost that if you find a small lump and it is immediate or early stages that it costs $10,000 or less to the trust fund. If you let breast cancer advance, it costs more than $60,000, and you are probably going to lose that person's life. So what is the point of what we are doing? I am just pleading with you to pass—I don't care whose name is on the bill.

It does not matter to me if it is my bill. Terrific. It doesn't matter whose bill it is. Pass it and get it done and do it tomorrow. That is what you should be doing. God bless you for having the hearing.

Mr. Chairman, I will see you later at the Pepper Commission and all the many hours we will be debating issues with our friend, Bill Gradison and others. I am just very pleased to have a chance to expand and expound on this issue because I am going to keep at it until you people on this committee pass it out and get it to the American people and their families.

Thank you very much, Mr. Chairman.

[The statement of Ms. Oakar follows:]

STATEMENT OF THE HONORABLE MARY ROSE OAKAR
MEMBER OF CONGRESS FROM OHIO
to the
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
February 27, 1990

I WOULD LIKE TO THANK YOU MR. CHAIRMAN, ALONG WITH THE MEMBERS OF THE SUBCOMMITTEE, FOR ALLOWING ME THE OPPORTUNITY TO GIVE THIS TESTIMONY TODAY. I AM VERY PLEASED TO BE HERE, ALONG WITH MY DISTINGUISHED COLLEAGUE FROM CALIFORNIA, REPRESENTATIVE BOXER, AND THE OTHER DISTINGUISHED PANELISTS YOU HAVE ASSEMBLED, TO ADDRESS THE SUECOMMITTEE.

MR. CHAIRMAN, I WOULD LIKE TO BEGIN MY STATEMENT BY RECOGNIZING AND APPLAUDING YOUR LEADERSHIP ON THIS SUBCOMMITTEE AND YOUR COMMITMENT TO BRINGING COST-EFFECTIVE PREVENTIVE HEALTH CARE TO OUR NATIONAL HEALTH POLICY. AS, YOU KNOW, I AM AMONG THE 49 ORIGINAL COSPONSORS OF HR 3880, AND I HIGHLY COMMEND YOU, NOT ONLY FOR YOUR EFFORT RESTORE LOST BENEFITS TO MEDICARE BENEFICIARIES, BUT ALSO FOR YOUR PROMPT ACTION ON THIS BILL, AS EVIDENCED BY THIS HEARING TODAY. I AM PROUD TO SERVE WITH BOTH YOU AND MR. GRADISON, MY COLLEAGUE FROM OHIO AND THE DISTINGUISHED RANKING MINORITY MEMBER OF THIS SUBCOMMITTEE, ON THE PEPPER COMMISSION, WHICH IS PRESENTLY STUDYING ALTERNATIVES TO OUR CURRENTLY INADEQUATE AND FAILING HEALTH CARE SYSTEM.

JUST A FEW MONTHS AGO, WHEN THE MAMMOGRAPHY SCREENING BENEFIT WAS REPEALED FROM MEDICARE, WE REPEALED WHAT, AT THAT TIME, WAS THE FIRST AND ONLY PREVENTIVE HEALTH BENEFIT OFFERED IN THE MEDICARE PROGRAM.

WE LOST THAT BATTLE, MR. CHAIRMAN, ALTHOUGH YOU AND I AND OTHERS HERE TODAY FOUGHT HARD TO KEEP THOSE COST SAVING BENEFITS. YET I KNOW, IN GREAT PART TO YOUR EFFORTS, MEDICARE NOW OFFERS ANOTHER PREVENTIVE, LIFE-SAVING BENEFIT -- PAP SMEARS, WHICH WERE ROLLED INTO THE MEDICARE PROGRAM THROUGH BUDGET RECONCILIATION. SO I KNOW THAT YOUR LEADERSHIP AND THE BATTLES WE HAVE FOUGHT TOGETHER ARE PAYING OFF -- OUR NATION IS MOVING IN THE RIGHT DIRECTION IN TERMS OF CORRECTING THE BACKWARDNESS OF OUR NATIONAL HEALTH POLICY.

MR. CHAIRMAN HR 3880, THE MEDICARE BENEFITS IMPROVEMENTS ACT OF 1990, INTRODUCED BY YOU IN A BIPARTISAN FASHION WITH REPRESENTATIVE GRADISON, WILL RESTORE VITAL BENEFITS TO DISABLED AND OLDER AMERICANS THAT WERE THROWN OUT "WITH THE BATH WATER" AS THEY SAY, WHEN CONGRESS REPEALED THAT SUPPLEMENTAL MEDICARE SURTAX WHICH WAS SO OFFENSIVE TO OLDER AMERICANS. THOSE WHO SERVE ON THE PEPPER COMMISSION, AND MANY OTHERS DIRECTLY CONCERNED WITH HEALTH POLICY ARE NOW BEGINNING TO UNDERSTAND, AS MANY OF US HAVE BEEN SAYING FOR YEARS -- WHEN FEASIBLE, REIMBURSEMENT TO QUALIFIED HEALTH PROFESSIONALS FOR THE PROVISION OF HOME HEALTH CARE AND HOSPICE CARE IS NOT ONLY HUMANE -- THESE BENEFITS CAN SAVE OUR HEALTH CARE SYSTEM A GREAT DEAL OF MONEY. CONSEQUENTLY, THE REST OF OUR ECONOMY BENEFITS. THERE IS A COST BENEFIT TO HOSPICE COVERAGE. FAMILY MEMBERS CAN FEEL LESS BURDENED BY THE NEED TO CARE FOR ELDERLY PARENTS OR DISABLED RELATIVES AND CAN BECOME MORE PRODUCTIVE MEMBERS OF SOCIETY. HOME HEALTH CARE ALLOWS PATIENTS TO BE CARED FOR IN THE COMFORT OF THEIR OWN HOME, AND STUDIES BEAR OUT THAT OFTEN, THIS OPTION GIVES PATIENTS A PSYCHOLOGICAL EDGE WHICH CAN SPEED UP RECOVERY TIME AND SAVE MEDICARE THE EXPENSIVE COSTS OF ROOM AND BOARD.

UNFORTUNATELY, THERE IS NOT ALWAYS A DIRECT RETURN ON INVESTMENT FOR INNOVATIVE HEALTH CARE BENEFITS. THAT IS TO SAY, THE COST SAVINGS MAY BE SEEN WHEN A FAMILY FINDS THEY ARE ABLE TO RETURN FULL TIME TO THE WORKFORCE, RATHER THAN SPEND THEIR DAYS AT HOME CARING FOR A FAMILY MEMBER. OR ELSE, WHEN AN OLDER AMERICAN IS ABLE TO AVOID PREMATURE ENTRY INTO A NURSING HOME SETTING, THEY CAN AVOID THE IMPOVERISHMENT THAT USUALLY FOLLOWS, WHICH EVENTUALLY LANDS THEM IN THE MEDICAID SYSTEM. YET, THE MONEY SAVED BY THE BENEFIT DOES NOT ALWAYS IMMEDIATELY RETURN TO THE MEDICARE SYSTEM. THE POINT I AM TRYING TO MAKE HERE IS THAT WHEN

WE ASK THE QUESTION TODAY, "WHAT DO THESE BENEFITS COST?," WE SHOULD CONSIDER THE COSTS OF NOT OFFERING SUCH BENEFITS. I HAVE SOME ACQUIRED SOME UPDATED FIGURES ON A 1982 STUDY DONE BY THOMAS HODGSON AND DOROTHY RICE WHICH WAS SUPPORTED BY THE NATIONAL CENTER FOR HEALTH STATISTICS, ENTITLED "ECONOMIC IMPACT OF CANCER IN THE UNITED STATES." THE STUDY ESTIMATES THE TOTAL COST OF CANCER MORTALITY IN THE UNITED STATES THROUGH A REGRESSION ANALYSIS OF VARIOUS TANGIBLES AND INTANGIBLES INCLUDING NOT ONLY MEDICAL EXPENSES BUT OTHERS VARIABLES SUCH AS VOCATIONAL RETRAINING,HOUSEHOLD AND FAMILY EXPENDITURES AND LOST PRODUCTIVITY IN GENERAL. THE UPDATED VERSION OF THIS STUDY STATES THAT IN 1985, BREAST CANCER MORTALITY COST THE UNITED STATES ECONOMY APPROXIMATELY $5.1 BILLION, OR $128 THOUSAND PER BREAST CANCER DEATH. WE MUST RESOLVE TO VIEW HEALTH CARE SPENDING AS AN INVESTMENT.

THIS BRINGS ME TO THE DISCUSSION OF THE MAMMOGRAPHY SCREENING BENEFIT OFFERED IN HR 3880. IT CAN BE SHOWN THAT THERE CAN BE AN IMMEDIATE SAVINGS WHEN WE OFFER LOW COST SCREENING TO WOMEN UNDER MEDICARE. AS I HAVE POINTED OUT BEFORE THIS SUBCOMMITTEE IN THE PAST, BREAST CANCER DETECTED IN ITS EARLIEST STAGE OF DEVELOPMENT CAN COST AROUND $15,000-20,000 TO TREAT. TUMORS DETECTED AT A LATER STAGE WILL COST, ON AVERAGE, $60,000 OR MORE TO TREAT. ONCE A TUMOR BECOMES LARGE ENOUGH FOR A WOMAN TO DETECT ON HER OWN, CHANCES OF SURVIVAL BECOME INCREASINGLY REMOTE.

MR. CHAIRMAN, I DO NOT NEED TO TELL YOU MOST MEDICARE BENEFICIARIES IN THIS COUNTRY ARE WOMEN. AS A MEMBER OF THE SELECT COMMITTEE ON AGING AND CHAIR OF THE AGING COMMITTEE TASK FORCE ON SOCIAL SECURITY AND WOMEN, I CAN TELL YOU THAT WOMEN ON FIXED INCOMES HAVE VERY FEW OPTIONS WITH RESPECT TO THEIR PERSONAL HEALTH CARE. THIS YEAR, 14,000 WOMEN COVERED UNDER MEDICARE WILL BE DIAGNOSED WITH BREAST CANCER, AND APPROXIMATELY 4,000 WILL DIE. BREAST CANCER IS NOW THE SECOND LARGEST KILLER OF WOMEN IN THE UNITED STATES AND IN THE LAST SIX YEARS OVER 220,000 HAVE DIED FROM BREAST CANCER. EARLY SCREENING COULD HAVE PREVENTED MOST OF THESE DEATHS.

EARLY IN THE 101st CONGRESS, I INTRODUCED HR 209 TO AMEND MEDICARE'S BIENNIAL SCREENING BENEFIT, THE ONE REPEALED AND NOW CONTAINED IN HR 3880, TO ALLOW FOR ANNUAL SCREENING. THE NATIONAL CANCER INSTITUTE AND THE AMERICAN CANCER SOCIETY RECOMMEND A BASELINE MAMMOGRAPHY FOR ALL WOMEN AT AGE 35 AND REGULAR SCREENING AFTER AGE 40 BASED ON A PHYSICIAN'S ADVICE, AND ANNUAL SCREENING AFTER AGE 50. TUMORS CAN GROW RAPIDLY, ESPECIALLY IN YOUNGER WOMEN, AND CAN GROW UNDETECTED FOR A LONG TIME. IN ADDITION, NEW FINDINGS HAVE EMERGED FROM THE BREAST CANCER DEMONSTRATION PROJECTS AT THE NATIONAL CANCER INSTITUTE THAT ALLOW PHYSICIANS TO PREDICT MORE ACCURATELY A WOMAN'S RISK FOR BREAST CANCER, BASED ON HER PERSONAL MEDICAL HISTORY. NEW EVIDENCE IS ALSO EMERGING WHICH ALLOWS PHYSICIANS TO PREDICT MORE ACCURATELY WHETHER OR NOT A TUMOR WILL RECUR.

I HAVE REINTRODUCED MY OWN LEGISLATION, HR 3864, "THE ROSE KUSHNER MAMMOGRAPHY SCREENING ACT OF 1990." I NAMED THIS BILL AFTER THE LATE ROSE KUSHNER WHOSE NAME WILL BE INSTANTLY RECOGNIZED BY ANYONE WHO WAS EVER INVOLVED IN ISSUES OF ADVOCACY FOR CANCER PATIENTS. SHE DISTINGUISHED HERSELF AS AN APPOINTEE OF PRESIDENT CARTER TO THE NATIONAL CANCER ADVISORY BOARD, AND HAS TESTIFIED BEFORE CONGRESS ON THIS ISSUE SEVERAL TIMES IN THE PAST. ROSE KUSHNER, AFTER DEVOTING HER LIFE TO THE CARE AND COMFORT OF CANCER PATIENTS, LOST HER OWN 14 YEAR STRUGGLE WITH THIS HORRIBLE DISEASE EARLY IN JANUARY -- OTHERWISE SHE WOULD BE HERE TODAY. ROSE HELPED ME DRAFT THIS LEGISLATION WHICH BEARS HER NAME. ROSE WAS A CO-FOUNDER OF THE NATIONAL ALLIANCE OF BREAST CANCER ORGANIZATIONS (NABCO) AND I AM PLEASED THAT THEY ARE REPRESENTED HERE TODAY IN THE PERSON OF AMY SCHIFFMAN LANGER.

MY BILL OFFERS A BASELINE SCREENING TO WOMEN UNDER MEDICARE AT AGE 35, AND NO MORE THAN ONE SCREENING PER YEAR, AFTER AGE 40 BASED ON THE ADVICE OF THEIR PHYSICIAN. THIS IS REASONABLE BASED ON THE NEW EVIDENCE WHICH ALLOWS PHYSICIANS TO DETERMINE ON A CASE BY CASE BASIS, WHO IS HIGH RISK. IT DOES NOT MEAN THAT ALL WOMEN WILL RECEIVE ANNUAL SCREENING REGARDLESS OF THEIR NEED. MY LEGISLATION ALSO INCLUDES A $60 CAP ON PHYSICIAN PAYMENT. THIS STRIKES A REASONABLE BALANCE BETWEEN THE NEED TO CONTAIN COSTS AND THE NEED TO ADEQUATELY COMPENSATE THOSE RECEIVING PAYMENT FOR THE BENEFIT.

ROSE KUSHNER WAS ALSO A CONSULTANT FOR LEGISLATION I HAVE INTRODUCED TO INCREASE FUNDING AT NCI FOR CANCER RESEARCH, HR 3251, AND HR 200 THE BREAST CANCER INFORMED DECISION ACT. WITH THE LOSS OF ROSE KUSHNER THIS YEAR AND THE DEATH OF CLAUDE PEPPER LAST YEAR, CANCER PATIENTS IN THE UNITED STATES HAVE LOST THEIR TWO GREATEST CHAMPIONS WITHIN THE LAST 12 MONTHS. IT IS NOW UP TO SOMEONE ELSE TO CARRY ON THEIR BATTLES, AND WITH THE HELP OF EVERYONE PRESENT, IN PERSON OR IN SPIRIT, I HOPE WE CAN DO THAT.

ON A FINAL NOTE, I WOULD LIKE TO POINT OUT THAT LAST FALL AS THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) WAS GEARING UP TO IMPLEMENT THE MEDICARE MAMMOGRAPHY BENEFIT, THEY PUBLISHED THEIR PROPOSED REGULATIONS FOR CONDITIONS OF REIMBURSEMENT UNDER THE PROGRAM. THE AMERICAN COLLEGE OF RADIOLOGISTS CURRENTLY HAS VERY STRICT QUALITY CONTROL REQUIREMENTS FOR THEIR MEMBERS WHICH PROTECT PATIENTS BY ENSURING THAT THOSE WHO CONDUCT MAMMOGRAPHY SCREENINGS ARE QUALIFIED AND ARE USING SAFE, RELIABLE METHODS. STRICTLY ENFORCED STANDARDS ARE ESSENTIAL FOR THE PROTECTION OF PATIENTS AND THE COLLEGE HAS TAKEN PAINS TO PROTECT THE INTEGRITY OF THEIR MEMBERS AND THE WELL-BEING OF PATIENTS BY MAKING SURE THAT PROVIDERS MEET ADEQUATE CONTINUING EDUCATION REQUIREMENTS AND SCREENING STANDARDS. HOWEVER THE REGULATIONS PROPOSED BY HCFA WENT SO FAR AS TO REQUIRE PATIENT SCREENING QUOTAS AND CONTINUING EDUCATION REQUIREMENTS THAT IT IS LIKELY, IF THEY WERE IMPLEMENTED, VERY FEW OF EVEN THE MOST HIGHLY QUALIFIED MEDICAL PROFESSIONALS COULD HAVE BEEN REIMBURSED UNDER THE BENEFIT. THIS TYPE OF REGULATORY OVERKILL, IN MY MIND, NEEDS TO BE AVOIDED IF ALL WOMEN COVERED UNDER MEDICARE ARE TO HAVE EQUAL ACCESS TO SCREENING. I REPEAT, STRICT SAFEGUARDS ARE ESSENTIAL AND I FEEL THAT THE RECOMMENDATIONS OF THE AMERICAN COLLEGE OF RADIOLOGISTS PROVIDE THE FULL PROTECTION THAT PATIENTS NEED. I HOPE THAT IF THE COMMITTEE MARKS UP THIS LEGISLATION, REPORT LANGUAGE CAN BE DRAFTED THAT SPELLS OUT EXACTLY WHAT IS EXPECTED OF HCFA IN DRAFTING THESE REIMBURSEMENT GUIDELINES.

IN CLOSING, MR. CHAIRMAN, I URGE THE MEMBERS OF THE SUBCOMMITTEE TO CONSIDER ANNUAL SCREENING AS A REAL OPTION AS THIS LEGISLATION PROCEEDS. BEYOND THAT, I FULLY SUPPORT WHAT YOU ARE DOING HERE TODAY. THANK YOU AGAIN FOR ALLOWING ME THIS OPPORTUNITY TO TESTIFY ON THIS MOST IMPORTANT ISSUE.

Chairman STARK. Barbara.

STATEMENT OF HON. BARBARA BOXER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. BOXER. Thank you, Mr. Chairman. I will be just about 2 or 3 minutes.

I have some very specific things to point out, and on the same subject I want to dedicate my testimony today to Louise Renne, who is the city attorney of San Francisco. Mr. Chairman, I think you know a few days ago she came forward and said she had suffered from breast cancer. She was fighting it.

It was detected fairly early, and I just spoke with her a couple of minutes ago. She sent her best to you and asked me to say for her that whatever this committee can do to promote early screening, it would just be critically important.

First of all, I must thank you, Mr. Chairman, for your leadership, not only on this issue, but all health issues. They are very contentious. They are very expensive. They are very difficult, and you have the knowledge and the courage to move forward these important issues.

What you do here regarding Medicare is very important because you know that the States will follow, Mr. Chairman, what you and Mr. Gradison and others do. The private sector will also follow, so whatever you do on mammography screening is critical.

I think it is important for you to note, Mr. Chairman, this will be of great interest. I took a poll in the district, in your area and mine, as to what mammography screening costs in the Bay Area, and I would like to ask you to listen to these quotes.

In Marin County you can get a mammography test for $95. In Children's Hospital in San Francisco it is $135. I just want you to hear this because it is in your district.

Chairman STARK. OK.

Mrs. BOXER. In Oakland at Merrit Peralta you have the lowest price. If a woman goes in she can get a mammogram for $70 if it is billed. At Alta Bates in Berkeley it is $95; at San Francisco General, $160; $77 at Highland Hospital. I think the point I am making, and the GAO study confirms it, if you cap these mammograms, Mr. Chairman, at $50, it is going to be very, very difficult for us to make this program a success.

I would urge you for mammography screening, don't cap the test. Keep it at a reasonable reimbursement or we won't have any luck in changing the course of this disease. Just for purposes of the study, the GAO study I cited said over 50 percent of those responding who were providers charge over $100 for the mammography.

Only 7 percent charge less than $50. Ninety-three percent charge more than $50, so to cap this at $50, Mr. Chairman, is a real problem for us in practical terms.

Chairman STARK. If the gentlelady would yield, there is another approach, and that might be to require the hospitals to do what Providence does and take the $50 and do the test and—

Mrs. BOXER. You mean to force them to accept the $50?

Chairman STARK. A mandatory assignment and not allow the extra bill. I am not suggesting that is the only approach, but it is an alternate to paying just whatever the hospitals ask for.

Mrs. BOXER. Well, Mr. Chairman, I am going to leave decisions of that nature to this committee to debate. I think, however, there is another point I want you to consider because it is very important.

The only way we got on top of the cervical cancer rate and literally brought it down, far down, was when we made the Pap smears available in a doctor's office, OK? It is very important, and I want to say to you that I think if you are going to stick to a $50 rate, I don't see how we are going to bring that kind of test into a doctor's office, and I tell you this because compliance with mammograms—and right now women know how important it is—is only 15 percent.

We are losing women. I won't go into the numbers. One out of every ten women is going to get breast cancer. The death rate has not dropped at all. It has stayed the same, even after mammography, because there is only 15 percent compliance.

I would urge you, and I am going to sum up here because I really only had these basic two points to make. Number 1, the $50 is not reasonable if you consider all the studies that have been done. Now, it is up to this committee to determine whether or not people are greedy. I don't know that, Mr. Chairman.

You have those facts, but the second point is, if we are going to wipe this disease out, if we are going to at least be able to treat it early and really drop those rates, I think you have got to do what you do with the Pap smeares and bring them into a suitable setting.

You and I have elderly moms. I don't see how our mothers—I know mine couldn't—step into a cold van going down some street. However, if she is having her annual check up, she can get that mammography, so those are my two points.

I salute you for what you are doing. I think we have a chance in this committee to literally save so many lives. Just as this Congress does from time to time, it could be a miracle, but we have to be able to be honest with ourselves as to how we are going to get women to get this screening.

I will stop at that point and leave the decisions to you and tell you that I am ready to work with you and Mary Rose Oakar and anyone else on this issue. Thank you.

[The prepared statement follows:]

BARBARA BOXER
6TH DISTRICT, CALIFORNIA

COMMITTEE ON THE BUDGET
HUMAN RESOURCES TASK FORCE CHAIRMAN

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

COMMITTEE ON ARMED SERVICES
(ON LEAVE)

MILITARY REFORM CAUCUS
CO-CHAIRMAN

WHIP AT LARGE

Congress of the United States
House of Representatives
Washington, DC 20515

307 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-5161

DISTRICT OFFICES

SAN FRANCISCO
450 GOLDEN GATE AVENUE
SAN FRANCISCO, CA 94102
(415) 626-8943

MARIN
3301 KERNER BOULEVARD
SAN RAFAEL, CA 94901
(415) 457-7272

VALLEJO
(707) 552-0720

SONOMA
(707) 763-5023

Testimony of Representative Barbara Boxer
Before the Health Subcommittee on Ways and Means
February 27, 1990

Thank you for inviting me to appear before you today, and thank you Mr. Chairman, for your leadership on health issues. I have a few specific points I would like to make about the issue of reimbursement for mammography screening by Medicare, but first, I would like to take this opportunity to dedicate my testimony to San Francisco City Attorney Louise Renne.

Louise recently had the courage to come forward to tell her story of her fight against breast cancer in order to encourage better breast cancer prevention. Breast cancer is still one of the leading causes of death among women, and mammography screening is critical to its early detection and to saving lives.

Mr. Chairman, what we do here in Congress is crucial because the states and the private sector are sure to follow Medicare's lead in setting a reimbursement rate for the cost of a mammography. Knowing this, I am very concerned that the $50 cap proposed in your legislation is unreasonable and practically impossible.

In an informal survey of mammography costs in the Bay Area, which I conducted just today, I found that a woman may have to pay anywhere from $70 to $177 for this vital test. A mammography in Marin County costs $95, a mammography at Merrit Peralta Hospital in Oakland costs $60 if she pays cash, $70 to bill her insurance, a mammography at Children's Hospital in San Francisco costs $135, and a mammography at Highland Hospital, in your own district Mr. Chairman, costs $177.

These results are supported by a recent GAO study which showed that over 50% of sites surveyed charged over $100, only 7% charged $50 or less, and 93% charged more than $50.

Second, compliance with mammographies is only 15% among women of all ages. In order to reverse breast cancer death rates, it is critical that mammograpy screening is widely available to women in all kinds of settings, including her own doctor's office.

Especially for an older woman, I think it is highly unrealistic to assume that she would use a mobile van to have a mammography. It seems much more likely that the she would have a mammography when she visits her doctor for an annual check-up.

Women now have pap smears in their doctor's office, and as a result, the death rate from cervical cancer has gone down by 50%. In contrast, breast cancer death rates remain unchanged.

A higher rate of reimbursement for mammography, or perhaps a differential rate of reimbursement based on the setting, would make mammographies more feasible.

I hope that you will take steps to set up reimbursement rates which are first of all realistic, and second, encourage mammography screenings in the most easily accessible setting.

Thank you.

Chairman STARK. Thank you. I just have one question. I appreciate your testimony and Ms. Oakar's, but don't you think that it is absolutely atrocious for the Budget Committee to be considering only a $3 billion cut in a $300 billion defense budget and asking this committee to cut $5 billion out of Medicare?

Mrs. BOXER. Not only do I think it is atrocious, I think it is absurd. I think it is ridiculous, and I want you to know that as the Chair of the Human Resources Task Force, I am not going to let that happen.

Chairman STARK. We are looking forward to you not doing that, too. Thank you very much. Mr. Gradison?

Mr. CRANE. Is the gentlelady leaving before I have a chance to question her?

Mrs. BOXER. Oh, I am sorry, I thought I was being excused by the Chairman.

Mr. DONNELLY [presiding]. Do any members of the panel have any questions for the panel? Mr. Chandler.

Mr. CHANDLER. Well, this is not in the form of a question, Mr. Chairman. I wanted the panel and our colleagues who have testified to know that I have introduced today along with our colleague, Mr. Schulze, a piece of legislation that only addresses two detections for cancer, that being mammography and colorectal screening.

These would be new benefits under part B very similar to the catastrophic benefit that, of course, was repealed. That bill is going in today.

Mr. DONNELLY. Thank you.

Barbara, if I could just make one comment and ask a question. I think you make some valid criticisms about the reimbursement mechanism in the bill. Clearly, if we are going to do this and the other minor expansions of Medicare, we need to do them right. Fifty dollars probably isn't enough. And furthermore, I personally don't like to see an open-ended ability by the physicians to bill whatever they feel is necessary because there is no mandatory assignment in this legislation.

But the committee would have to work its will on that. Just let me ask you this question as we sort of restructure some of the benefits that were repealed along with the major catastrophic benefit.

Will we be able to deal with the whole issue of duplication of benefits that became one of the real problems with the catastrophic legislation? In other words, seniors and Medicare beneficiaries may already have part or all of this type of coverage that is part and parcel of the Stark-Gradison bill in their health policies for their retirement. Under this bill we are adding an additional fee on to every Medicare beneficiary.

Mrs. BOXER. So the question is, what about the people who already have private insurance?

Mr. DONNELLY. Exactly. The same objection that was raised.

Mrs. BOXER. I understand. I think you treat it just the way we said we would treat catastrophic, that we would hope that if more benefits are provided by Medicare that the private insurance rates would drop and that they wouldn't need that benefit once it is a mandated benefit of Medicare. And I think what you are doing

here, if you make this decision, you are elevating this issue to where it belongs.

It is a killer, and therefore everyone should have the coverage and therefore the person who has the private coverage doesn't need the mammography coverage and presumably rates would drop and they wouldn't need that coverage.

Mr. DONNELLY. Of course what catastrophic showed us is that rates, in fact, did not drop.

Mrs. BOXER. That was a horrible part of what happened. I think we need to investigate why that didn't happen, but still in all, I think you could have asked that question forever when you started with Medicare.

Maybe we didn't need Medicare at all because some people had private coverage. The fact is there are certain things that older people need—mammograms, and I also would be so pleased to help Mr. Chandler with his bill. The colonoscopy is another issue that hits the elderly very hard.

We are elevating these diseases to a higher level in the hope of preventing death.

Mr. DONNELLY. Would you have any objection to making this small expansion of Medicare benefits voluntary as an option for the beneficiaries to choose? Not only choose in the benefit, but also at the same time choosing the cost of the benefit, too.

Mrs. BOXER. I would have to think it over and look at the pros and consequences. At first blush—

Mr. DONNELLY. Similar to the same system we have as working Americans and on an annual basis many of us—Federal Government employees, for example choose during open season what sort of coverage fits us in our particular circumstances during that time.

Mrs. BOXER. At first blush it seems like a reasonable thing, but sometimes in health care I find out that something that sounds reasonable you have to study a little longer. At first blush it sounds very good to me, but I would have to see—my concern is to get mammography screening in particular to all the women of this country.

I mean, not just the elderly, but that is what we are talking about today. If I would be sure that those people would choose that coverage, it would be OK. But suppose it was voluntary and the husband and wife sat down and the husband said, well I don't want to spend $4 more a month, you don't need this mammography screening. So I really have to look at it and see if it is the right thing to do to meet the goal I have that I know we all share, which is to get early screening of mammography.

If you could prove to me that would do it, I would love to go the voluntary route.

Mr. DONNELLY. I am totally supportive of the benefit. I worked with members of the women's caucus when we included it in conference on the original catastrophic legislation in the last Congress. But this is just the beginning of, I suspect, a series of very good proposals for additional expanded Medicare coverage that are very necessary to protect the health needs of 30-odd million Medicare beneficiaries.

I guess the question is when are we going to retrofit the Medicare system to the other health care systems in this country and eliminate this whole problem of duplication of benefits. Because if we don't, having gone through the whole process of enacting catastrophic and then having to repeal it, we don't want to put ourselves into that situation again, and that is why I just would ask you to sort of think through the whole issue of making some of these expanded benefits available to the beneficiaries on a voluntary, open-season basis.

Mrs. BOXER. Mr. Donnelly, could I ask you how it would work? I am an elderly woman. I am living on my Social Security with my husband, and we get a notice in the mail. Let's say I am 70 years old. I get a notice in the mail. We read it together. It says Medicare has expanded your possibilities. You can now get coverage for Medicare and colonoscopy if you pay *x* number of dollars more per month.

Is that what you are suggesting?

Mr. DONNELLY. Exactly.

Mrs. BOXER. Now how would you set what that approximate number of dollars would be? Wouldn't it depend on how many people——

Mr. DONNELLY. It would be set on the same actuarial basis as the private insurers do. You would basically assume a certain percentage of the beneficiaries would accept the service at a certain cost and then you would set the flat monthly or yearly fee.

Clearly, you would assume that not all of the beneficiaries would accept this sort of optional package, so that would drive up the monthly cost of the premium. Now with all of the 30-odd million Medicare beneficiaries being mandated to accept these additional coverages, that is why we are able to offer a fee at a fairly low cost to all the beneficiaries.

It is just not this issue, Barbara. I think it is the whole issue of where we go in terms of financing and making available additional benefits at reasonable cost.

Mrs. BOXER. And not duplicate.

Mr. DONNELLY. And not duplicate the benefits for individuals whether through union policies deferred compensation, or health care retirement policies had earned these benefits during their working years.

I think that was one of the real problems with the catastrophic legislation.

Mrs. BOXER. Absolutely. I am very open to working with you to see the best way to work on this.

Mr. DONNELLY. Thank you very much.

Mr. Cardin.

Thank you very much.

Mrs. BOXER. Thank you all very much.

Chairman STARK. Barbara, I was just talking with the staff about your question. I hate to remind us both that our area is a very high cost area, but we have been informed that not many women would be denied the opportunity to have a mammogram for $50 across the country. There are some high cost areas, the San Francisco Bay area being one.

As you indicated, Providence Hospital is at $60, which is pretty close. You are going to have some unhappy providers, but the thought is that there would be such a large market out there in increased volume that with a little public pressure, these tests would probably be available to most everyone at the $50.

Mrs. BOXER. I was just reporting to you, Mr. Chairman, the current status, which is that 93 percent of the providers today charge more than $50. Now, I am just reporting that is the result of the study, and 50 percent, 52 percent charge more than $100. So I just want to urge you that whatever you do, and I know how strongly you feel about people who overcharge, who are unfair, who inflate costs, and I trust you in that.

But the same point I just want to point out that we don't want to have this so restricted that it doesn't help to have it out there, and it may stop the tests from moving into a doctor's office and maybe it means you have different reimbursements for different settings. I really don't have the answers.

I have a lot of questions. I want to work with you, but I want you to feel that once you give this benefit it is going to do what we want, which is to reduce the death rate. I think we could do it if we are fair and reasonable.

Chairman STARK. A point well-taken. Thank you.

Our next panel——

Mrs. JOHNSON. Mr. Chairman, I just wanted to——

Chairman STARK. I am sorry.

Mrs. JOHNSON. I just wondered if you had any information on what percentage of the medigap policies cover mammography.

Mrs. BOXER. I do not.

Mrs. JOHNSON. I think we need to get that information. I look forward to working with you.

Mrs. BOXER. That is a very good question.

Now I will leave, Mr. Chairman, if there is nothing further.

Chairman STARK. Thank you.

Our first panel will consist of Dr. Gerald Dodd, president-elect of the American Cancer Society, and Ms. Amy Langer, the administrative director of the National Alliance of Breast Cancer Organizations.

I would like to welcome the witnesses and state that your prepared testimony will appear in the record in its entirety. We would appreciate it if you would care to summarize or expand on your prepared testimony or enlighten us in any manner you are comfortable.

We will start with Dr. Dodd. Please proceed.

STATEMENT OF GERALD D. DODD, M.D., PRESIDENT-ELECT, AMERICAN CANCER SOCIETY, PROFESSOR AND CHAIRMAN, DIVISION OF DIAGNOSTIC IMAGING, UNIVERSITY OF TEXAS, M.D. ANDERSON CANCER CENTER, HOUSTON, TEX.

Dr. DODD. Thank you. Good afternoon. I am pleased to be here today to discuss the American Cancer Society's support for the Medicare Benefits Improvement Act of 1990. My name is Gerald D. Dodd, and I am professor and chairman of the Division of Diagnostic Imaging at the University of Texas, M.D. Anderson Cancer

Center, and president-elect of the American Cancer Society—the Nation's largest voluntary, nonprofit health organization which is dedicated to the elimination of cancer as a major health problem.

The society commends you, Representative Stark, and other members of Congress here today who have taken the lead in shaping public policy related to cancer control issues. H.R. 3880 would restore several important and necessary benefits for cancer patients and their families that were lost with the repeal of the Medicare Catastrophic Coverage Act.

The American Cancer Society supports coverage for all of these benefits, and is especially pleased with the quality assurance focus given to the mammography screening benefit. Because of my professional background, I would like to restrict my remarks this afternoon to the breast cancer early detection component of H.R. 3880 and its impact on Medicare beneficiaries.

Approximately 150,900 cases of breast cancer will be diagnosed and 44,000 women will die of the disease in the United States this year. Overall, 1 out of every 10 women will develop breast cancer at some time, and more than half of these will be over 50 years of age.

We do not know what causes breast cancer, nor do we know how to prevent it. But appropriate use of screening mammography, in conjunction with clinical examination and breast self-examination can enable us to detect many breast cancers early in their development. Such cancers require less arduous treatment, and increase the chances for long-term survival by as much as 40 percent. Indeed, survival rates in excess of 90 percent can be achieved when the disease is detected in a subclinical stage.

The reliability of mammography as a screening tool has been adequately demonstrated by various clinical trials. Based on these studies, the American Cancer Society, the National Cancer Institute, the American College of Radiology and eight other major health organizations have developed medical guidelines designed to promote detection of early breast cancer.

These organizations recommend that an asymptomatic women age 40–49 should receive a mammogram every 1 to 2 years, depending on individual risk factors and that women age 50 and over should receive an annual mammogram. Unfortunately, factors such as cost, lack of information about the test, apathy, and fear of radiation or the results of the test represent barriers to the use of screening.

The results of a national health interview survey released by the National Center for Health Statistics last month found that 60 percent of women in the United States 40 years of age and over had never had a mammogram. Importantly, the NCHS survey and earlier studies done by the American Cancer Society found that the use of mammography is strongly associated with socioeconomic status.

The proportion of women reporting that their last mammogram was for routine, nonmedical reasons increased with education and even more so with income, suggesting that the cost of mammography may be a significant factor in the prevalence of its use as a screening procedure.

If the use of mammography is to become widespread, the following issues must be addressed. First, both physicians and the public must be made aware of the importance of mammography in breast cancer mortality reduction, and of the increasing availability of screening mammography so that these procedures are requested or recommended regularly. Many of the American Cancer Society's public and professional education programs are dedicated to this goal.

Second, the data clearly indicate that older women, those over 60, are more likely to get breast cancer, but are less likely to receive screening. A woman's risk for getting breast cancer increases significantly as she grows older.

The incidence per 100,000 women between the ages of 60 and 74 is 1.6 times that of the 45- to 59-year age group. Thus, educational efforts must be intensified and the procedure made more accessible through low cost, high quality screening centers.

Toward this end, the American Cancer Society in conjunction with the American College of Radiology, has established an accreditation program for mammography facilities. Additionally the society has advocated and publicized methods by which the costs of screening mammography can be lowered. H.R. 3880 clearly improves accessibility while assuring quality for screening women in this age group.

Mr. Chairman, and members of the subcommittee, the United States Congress has already recognized the life-saving potential of cancer early detection tests. Medicare now covers the Papanicolau test for its women enrollees, a screening that detects cervical cancer when it is almost completely curable. Similarly, a bill was introduced today by Representative Chandler to provide coverage for screening examinations designed to detect cancers of the breast, colon, and rectum.

Coverage for screening mammography was included in the Medicare Catastrophic Coverage Act, but the law's repeal has left a void. The legislation introduced by you, Congressman Stark and other bills introduced by your colleagues, Representatives Oakar, Collins, Vucanovich, and Chandler, would remedy that problem.

I thank you for allowing me the opportunity to testify, and I look forward to answering your questions.

[The statement of Dr. Dodd follows:]

TESTIMONY OF GERALD D. DODD., M.D.
AMERICAN CANCER SOCIETY

Good afternoon. I am pleased to be here today to discuss the American Cancer Society's support for the Medicare Benefits Improvement Act of 1990. My name is Dr. Gerald D. Dodd, and I am Professor and Chairman of the Division of Diagnostic Imaging at the University of Texas, M.D. Anderson Cancer Center in Houston, Texas, and President-Elect of the American Cancer Society -- the nation's largest voluntary, nonprofit health organization dedicated to the elimination of cancer as a major health threat to this nation.

The Society commends you, Representative Stark, and other Members of Congress here today who have taken the lead in shaping public policy related to cancer control issues. H.R. 3880 would restore several important and necessary benefits for cancer patients and their families that were lost with the repeal of the Medicare Catastrophic Coverage Act -- Medicare coverage for screening mammography, in-home respite care, home health services, and expansion of the hospice benefit. The American Cancer Society supports coverage for all of these benefits, and is especially pleased with the quality assurance focus given to the mammography screening benefit. Because of my professional background, I would like to restrict my remarks this afternoon to the breast cancer early detection component of H.R. 3880 and its impact on Medicare beneficiaries.

The American Cancer Society's 1990 Cancer Facts and Figures reports that approximately 150,900 new cases of breast cancer will be diagnosed and 44,000 women will die of the disease in the United States this year. Overall, one of every ten women will develop breast cancer at some time, and more than half of these breast cancer patients will be over 50 years of age. Breast cancer incidence rates have increased about 1% a year since the early 1970s and some of this is attributed to earlier detection of tumors through screening programs before they become clinically apparent -- some tumors can be found by mammography 2-4 years earlier than by physical examination. It is important to note that while incidence rates are increasing, early detection of the disease and improved treatment have kept mortality rates fairly stable over the past 50 years.

We do not yet know what causes breast cancer, nor do we know how to prevent it. But appropriate use of screening mammography, in conjunction with clinical examination and breast self-examination (BSE), as recommended by the American Cancer Society, can enable us to detect many breast cancers early in their development. Such cancers require less arduous treatment, and increase the chances for long-term survival by as much as 40 percent. Indeed, survival rates in excess of 90% can be achieved when the disease is detected in a subclinical stage.

For background, a mammogram is an x-ray examination of the breast. Either special x-ray films or xerography may be used for screening purposes. Both of these techniques, if properly performed by qualified technicians and radiologists, can provide excellent images with an absorbed x-ray dose of 1/5 to 1/2 rad for two views of each breast. This level of radiation has not been associated with any health risk.

The American Cancer Society believes that the reliability of mammography as a screening tool has been adequately demonstrated by various clinical trials, including the results of the Health Insurance Plan (HIP) of New York, the Breast Cancer Detection Demonstration Project (BCDDP) cosponsored by the National Cancer Institute and the American Cancer Society, and other major international studies in Sweden, Holland and Italy. Data from controlled trials clearly demonstrates that deaths from breast cancer are reduced by about 30% in women over 50 years of age.

A recent analysis of the Breast Cancer Detection Demonstration Project (BCDDP) data is also pertinent. The study offered annual mammography, physical examination, and BSE training to 280,000 women between the ages of 35 and 74 for five years. One-third of the 3,557 cancers detected in the project were minimal cancers. More than 75 percent of all cancers detected showed no evidence of lymph node involvement. Physical examination and mammography both contributed cases not detected by the other. The role of mammography was significantly greater; mammography alone found 40 percent of all cancers, compared with 10 percent by physical examination alone. The contribution of mammography was particularly noteworthy for infiltrating cancers less than one centimeter in diameter -- 53% were detected by mammography alone. The BCDDP, using newer mammographic technology, demonstrated that mammography alone found cancers in women age 40-49 at about twice the rate of the earlier HIP study.

Based on these studies, the American Cancer Society, the National Cancer Institute, the American College of Radiology and eight other major national health organizations have developed medical guidelines designed to promote early detection of breast cancer. These organizations recommend that asymptomatic women age 40-49 receive a mammogram every one to two years, depending upon individual risk factors. Women over age 50 should receive an annual mammogram. The American Cancer Society also recommends a baseline mammogram for women aged 35-39. Clinical examination, beginning at an early age, and regular breast self-examination are essential components of these early detection guidelines.

Given the medical value of mammography in breast cancer detection, one would assume that the procedure would be widely used. Unfortunately other factors such as cost, lack of information about the test, apathy, and fear of radiation or of the results represent barriers to the use of screening.

The results of a National Health Interview Survey released by the National Center for Health Statistics (NCHS) last month found that 60% of women in the United States 40 years of age and over had never had a mammogram. Thirteen percent had never heard of mammography, and 46 percent had never been examined although they were aware of the procedure. The proportion of women who had ever had a mammogram increased with age up to age 54 (39% of women 40-44 years; 46% of women 50-54 years), then decreased steadily to 18% of those 85 years and over. White women were more likely than black women to have had a mammogram (39% compared to 30%) when adjusted for all ages. The use of mammography was strongly associated with socioeconomic status. The proportion of women reporting that their last mammogram was for routine, nonmedical reasons increased with education, and even more so with income, suggesting that the cost of mammography may be a significant factor in the prevalence of its use as a screening procedure.

The results of the NCHS survey are similar to those reported in an earlier Gallup Poll survey sponsored by the American Cancer Society. An analysis of these results indicates that psychosocial factors related to women's use of screening tests include their awareness of the benefits of the test and the importance of screening in the absence of symptoms, geographical and financial accessibility, and other educational and economic factors. The survey also found that the patient-physician relationship plays a significant role in women's utilization of screening; physician opposition to screening is a strong deterrent.

If the use of mammography is to become more widespread, the following issues must be addressed: First, both physicians and the public must be made aware of the importance of mammography in breast cancer mortality reduction and of the increasing availability of screening mammography so that these procedures are

requested or recommended regularly. Many of the American Cancer Society's public and professional education programs are dedicated toward this goal.

Secondly, the data clearly indicate that older women (60 years and over) are more likely to get breast cancer, but are less likely to receive screening. A woman's risk for getting breast cancer increases significantly as she grows older; more than half of female breast cancers occur in women over age 50, and the incidence per 100,000 women between the ages of 60 and 74 is 1.6 times that of the 45-59 age group. Thus, educational efforts must be intensified and the procedure made more accessible through low-cost, high quality screening centers. Toward this end, the American Cancer Society, in conjunction with the American College of Radiology, has established an accreditation program for mammography facilities. Additionally, the Society has advocated and publicized methods by which the costs of screening mammography can be lowered. H.R. 3880 clearly improves accessibility, while assuring quality, for screening women in this age group for breast cancer.

Finally, because women of low socioeconomic status -- white, black, Hispanic and other ethnic groups -- are the least likely to know about the benefits of mammography or to be able to afford the procedure, health program planners and practitioners should focus on service delivery to this group. I am proud to tell you that the American Cancer Society, as part of its major initiative aimed at the underserved, funded three community cancer detection, education and prevention centers in Miami, Florida; Harlem, New York; and Oakland, California -- at a cost of $1.8 million over the next three years -- to provide cancer screening to the socioeconomically disadvantaged in these cities. These pilot projects will serve as models for cooperative ventures between the American Cancer Society and state/local organizations in other communities.

Mr. Chairman and Members of the Subcommittee, the United States Congress has already recognized the life-saving potential of cancer early detection tests by enacting laws to provide coverage for such procedures. Medicare now covers the Papanicolau (Pap) test for its women enrollees -- a screen that detects cervical cancer when it is almost completely curable. Similarly, a bill will be introduced today by Rep. Rod Chandler to provide coverage for screening exams designed to detect breast, colon and rectum cancers. Coverage for screening mammography was included in the Medicare Catastrophic Coverage Act, but that law's repeal has left a void.

In the coming decade, we face new challenges in the design of innovative approaches for the delivery of quality health care services. America is growing older, and we have the technology to allow us to live longer, more productive lives. The quality of that life is in part dependent upon early detection and treatment of disease. H.R. 3880 will provide access to an important segment of that technology, and contribute to the productive extension of many lives.

Thank you for allowing me the opportunity to testify. I look forward to answering your questions.

Chairman STARK. Thank you, Doctor.
Ms. Langer.

AMY SCHIFFMAN LANGER, ADMINISTRATIVE DIRECTOR, NATIONAL ALLIANCE OF BREAST CANCER ORGANIZATIONS (NABCO), NEW YORK, N.Y.

Ms. LANGER. Mr. Chairman, distinguished committee members, ladies and gentlemen. I am Amy Schiffman Langer, administrative director of the National Alliance of Breast Cancer Organizations (NABCO). I represent more than 180 member organizations throughout the country which provide breast cancer education, diagnosis and care to several hundred thousand American women.

Two years ago last month, NABCO presented testimony before a Senate committee on the benefits of screening mammography, and urged its coverage in the Medicare Catastrophic Coverage Act. Today, routine screening mammography can be regarded as a safe and reliable procedure, and its potential to reduce breast cancer mortality by more than 30 percent is widely acknowledged. With this as a starting point, I would like to review the reasons that the mammography coverage proposed in this act is so urgent, and so vital.

First is incidence. More than one-third of breast cancer cases are currently diagnosed in women over age 65. Breast cancer is the most common form of cancer in women, its cause unknown and its incidence increasing at approximately 1 percent annually. Age is the most significant risk factor, with incidence increasing dramatically after age 40. Although annual mammography screening after age 50 is almost universally recommended, a woman insured by Medicare is not reimbursed for her compliance.

Then, mortality. Despite treatment advances, the mortality rate from breast cancer has not changed in the United States for the past 60 years, and large scale studies have demonstrated that older women die from the disease at a disproportionately high rate. The ACS has reported that more than three-quarters of breast cancer deaths are of women over age 54, supported by BCDDP data demonstrating that breast cancer fatality was highest in the oldest group of women studied, women over age 59. The oldest group was the group most frequently diagnosed with invasive, advanced disease.

Survival data for older minority women is even more discouraging. Incidence of breast cancer is highest among white women, yet the 5-year survival rate among black women diagnosed is significantly lower; 62 percent as compared with 75 percent for white women.

Given these incidence and mortality rates, we can project that since the Catastrophic Coverage Act was repealed in late November, more than 12,500 American women over age 65 have been diagnosed with invasive breast cancer, and at least 3,000 have died from breast cancer. The statistics will continue to mount. It is dangerous to delay any further.

More positive statistics can be projected in anticipation of this bill's passage. It is clear that economic factors play a powerful role in a woman's decision to have a mammogram. Extending coverage

which makes mammography more affordable will help motivate the Medicare population to go for screening, principally a population with fixed and limited incomes facing skyrocketing health care costs.

In a 1987 study published last year it was found that 34 percent of women who had some type of private insurance reported having had a mammogram in the past year, as compared with 15 percent of women covered by Medicare, Medicaid or having no insurance.

Perhaps equally important will be the signaling value of our Congress in officially proclaiming its importance by making screening coverage a law. Among the many justifications that women use to avoid mammography is that the risk of breast cancer is just not that threatening, a belief that is simply incorrect.

Here is data about breast cancer that a 65-year-old woman currently entering the Medicare program may have heard when she was 50 years old, that she might mistakenly still believe to be valid: In 1975, although breast cancer was the most common form of cancer and most frequent cause of cancer death among women, a total of 88,000 new cases and 32,600 deaths were projected. In 1990, the ACS estimate is 150,000 new cases and 44,000 deaths. In the 1970's the radiation dose used for mammography was greater than 10 times the average dose used today, and breast cancer surgery was mutilating.

We might therefore suspect that some older women persist in believing that breast cancer is infrequent and unlikely, that mammography is dangerous and that surgical treatment is too drastic to contemplate. This may help explain why about 54 percent of women over 65 surveyed had never had a mammogram, compared with fewer than 40 percent in several younger age groups.

There is good news about breast cancer, but routine screening is the most effective way to assure continued good health, and it should be available to all American women, regardless of age. With this bill, lawmakers have the opportunity to truly make history, to follow through with a commitment to help deliver the preventive health care that women need and deserve.

We hope that once screening provisions are in place, Medicare will find it possible to cover annual screening, in conformance with recommended guidelines. One day, perhaps the increasing number of older American women will make breast cancer screening as routine as any other checkup, and with this habit, eliminate much of the pain and loss faced by breast cancer patients and their families every day. Medicare's provision of screening coverage would firmly lead us in this direction.

Thank you for the opportunity to address you on this critically important issue.

[The statement of Ms. Langer follows:]

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NATIONAL ALLIANCE OF BREAST CANCER ORGANIZATIONS

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Executive Director
Ruth Spear

Second Floor
1180 Avenue of the Americas
New York, N.Y. 10036
212-719-0154

Testimony of the

National Alliance of Breast Cancer Organizations

before the Subcommittee on Health,

House Committee on Ways and Means in Support of the

Mammography Screening Provisions of H.R. 3880

February 27, 1990

Mr. Chairman, distinguished Committee members, ladies and gentlemen. I am Amy Schiffman Langer, Administrative Director of the National Alliance of Breast Cancer Organizations (NABCO). I represent more than 180 member organizations throughout the country which provide breast cancer education, diagnosis and care to several hundred thousand American women.

Two years ago last month, NABCO and other experts presented testimony before the Senate Committee on Labor and Human Resources on the benefits of Medicare coverage of screening mammography, and urged its inclusion in the Medicare Catastrophic Coverage Act of 1988. I am encouraged that today, as a result of education programs and the support of Congress and the National Cancer Institute, routine screening mammography can be regarded as a safe and reliable procedure, and that its potential to reduce breast cancer mortality by more than 30 percent is widely acknowledged. With this as a starting point, I would like to review the reasons that the mammography coverage proposed in the Medicare Benefit Improvements Act of 1990 is so urgent, and so vital.

First is incidence. More than one third of breast cancer cases are currently diagnosed in women over age 65. Breast cancer is the most common form of cancer in women, its cause unknown and its incidence increasing at approximately 1% annually. Age is the most significant risk factor, with incidence increasing dramatically after age 40. Because of this risk, guidelines endorsed and promoted by the government's National Cancer Institute and ten national medical organizations recommend annual mammography screening after age 50. Yet, paradoxically, a woman insured by Medicare is not reimbursed for her compliance.

Then, mortality. Despite treatment advances, the mortality rate from breast cancer has not changed in the United States for the past 60 years. Large scale studies have demonstrated that older women die from the disease at a disproportionately high rate. The American Cancer Society (ACS) has reported that more than three-quarters of breast cancer deaths are of women over age 54. In the Breast Cancer Detection Demonstration Project, or BCDDP's, sample of 55,000 white women 35 to 74 years of age selected for follow-up, the rate of fatality from breast cancer over a five-year period was highest in the

oldest group, women over age 59. This is not surprising in light of this study's data revealing that at diagnosis, the oldest group was the group most frequently diagnosed with invasive, advanced disease.

Survival data for older minority women is even more discouraging. Incidence of breast cancer is highest among white women, yet the five-year survival rate among black women diagnosed with breast cancer is significantly lower: 62% as compared with 75% for white women, according to the ACS. The Surveillance, Epidemiology and End Results (SEER) program of the NCI reported that black women are at elevated risk for being diagnosed with the most advanced form of breast cancer.

Given these incidence and mortality rates, we can project that since the Catastrophic Coverage Act was repealed in late November, more than 12,500 American women over age 65 have been diagnosed with invasive breast cancer, and at least 3,000 have died from breast cancer. The statistics will continue to mount as this bill's benefits are debated. It is dangerous to delay any further.

More positive statistics can be projected anticipation of this bill's passage. It is clear that economic factors play a powerful role in a woman's decision to have a mammogram. Extending coverage which makes mammography more affordable will help motivate the Medicare population to go for screening. This is principally a population with fixed and limited incomes, facing skyrocketing health care costs. Recently The New York Times reported that since 1965, the year the Medicare program began, the yearly cost of health care in the United States has risen more than tenfold, and according to the AARP over 70 percent of older Americans living in poverty today are women.

In a 1987 study published last year in the American Journal of Public Health, Dr. Jane Zapka found that 34% of women who had some type of private insurance reported having had a mammogram in the past year, as compared with 15% of women covered by Medicare, Medicaid or having no insurance. Her study also showed that two-thirds of respondents with annual income in excess of $35,000 had had at least one mammogram, whereas only 40% of women with income below $15,000 had been screened.

Perhaps equally important will be the signaling value of our Congress in officially proclaiming the importance of screening by making screening coverage a law. Among the many justifications that women use to avoid mammography is that the risk of breast cancer is just not that threatening, a belief that is simply incorrect. To better understand, NABCO has assembled 1975 data about breast cancer, data that a 65-year old woman currently entering the Medicare program may have heard when she was 50 years old, and that she might still mistakenly believe to be valid.

- In 1975, although breast cancer was the most common form of cancer and most frequent cause of cancer death among women, a total of 88,000 new cases and 32,600 deaths were projected. In 1990, the ACS estimate is 150,000 new cases and 44,000 deaths.

- In 1975, fewer than one in 15 women were projected to develop breast cancer over their lifetimes. Today's rate is one in 10, and rising.

- In the 1970's, the radiation dose used for mammography was greater than 10 times the average dose used today, with two views per breast now used. Doubling the views vastly improved mammography's diagnostic ability.

- Breast cancer surgery in 1975 was mutilating, and supportive care hard to come by. Today, about a third of those patients who qualify select breast-conserving surgery, generally an option for women with small tumors whose cancer is detected early.

It therefore may not unfounded to suspect that some older women persist in believing that breast cancer is infrequent and unlikely, that mammography is dangerous and that surgical treatment is too drastic to contemplate, which may help explain Dr. Zapka's results: about 54% of the women over age 65 surveyed had never had a mammogram, compared with fewer than 40% in several younger age groups.

Education is necessary and valuable, and the NCI's efforts concerning breast cancer have been commendable. Many women, especially younger women, seem to have gotten the word that there is good news about breast cancer, and that routine screening is the most effective way to assure their continued good health. Screening should be available to all American women, regardless of age. With this bill, lawmakers have the opportunity to truly make history, to follow through with a commitment to help deliver the preventive health care that women need and deserve.

We hope that once screening provisions are in place, the Medicare program will find it possible to extend coverage of annual screening to all women 65 and over, in conformance with the mammography guidelines that experts universally recommend. One day, perhaps the increasing number of older American women will make breast cancer screening as routine as any other checkup, and with this habit, eliminate much of the pain and loss faced by breast cancer patients and their families every day. Medicare's provision of screening coverage would firmly lead us in this direction.

Thank you for the opportunity to address you on this critically important issue.

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Chairman STARK. Thank you, Ms. Langer.

Dr. Dodd, in regards to colon-rectal screening, it is our understanding from OTA that there is some disagreement or lack of unanimity concerning the clinical benefits of this screening, and—well, I suggest that any kind of preventive medicine that we could encourage would be beneficial when you are limited as we are in funds.

I wonder if there is a study or if there is a body of statistics to suggest that there is a major decrease in mortality as a result of these screenings.

Dr. DODD. I guess the most recent pertinent information on mortality reduction is that it is really due to prevention rather than treatment. Namely, the detection of polyps before they degenerate into a cancer.

There is no question about that, that that essentially lowers the mortality to zero.

Chairman STARK. I have a question for you, and I don't understand the question, but maybe you will, and that is whether there is an analyst or whether you have analyzed the cost of the screening follow-up and surveillance for elderly people using ACS/NCI guidelines.

Dr. DODD. Is that in respect to mammography or in general?

Chairman STARK. To the colon-rectal screening.

Dr. DODD. Of course, to the colon-rectal. Well, actually the colorectal recommendations by the American Cancer Society and the NCI are really directed toward the operating physician's office. They are not a screening mechanism.

It is not envisioned that large numbers of people would be processed in that way.

Chairman STARK. Ms. Langer, there are some who say that older women are least likely to benefit from early detection and that all the clinical trials have focused on younger women.

Is there any evidence that supports our claim or feeling that mammography screening would be beneficial for the older population?

Dr. DODD. About two-thirds of the cancers are in the older population. One third in the younger.

More recent data that is gradually coming out indicates that mammography is about as effective in the younger as in the older age groups, and it becomes a matter of a number of cases and an analysis in terms of cost benefit.

Ms. LANGER. I would just respond to your question that what is of most note is the tumor itself and its stage and not the age of the women it occurs in, that effectively any woman whose cancer is detected early has a better chance of surviving that cancer healthily than if it is detected at later stages.

We know mammography is an effective way to do that.

Chairman STARK. You were here when Mrs. Boxer testified about the problem. Ninety-three percent of the screening charges are over $50, but I think that there are two different kinds of tests. One is a screening and one is something else, and that is my understanding.

My staff can't quite support my understanding with any information, but could either of you shed any light on how close we are to

the idea that a majority of the women in this country could get a useful test for $50?

I think it is the screening test that is less expensive, but I can't think of the name of the other one right now.

Ms. LANGER. Diagnostic.

Chairman STARK. Maybe for the record you could enlighten the Chair as to just whether I am way off on this or what the facts are.

Dr. DODD. There are pretty well established mechanisms by which the cost can be lowered.

Chairman STARK. What are the two types of tests, Doctor?

Dr. DODD. Screening mammography or diagnostic mammography.

Chairman STARK. Screening is generally less expensive but it is just as effective?

Dr. DODD. It is as effective in initial detection, then there is further workup required. It is to separate those who have a potential abnormality from those who are normal.

Once you have the small group that are potentially abnormal, more definitive testing is necessary.

Ms. LANGER. I think the GAO report referred to by Barbara Boxer did give us some conclusions here, and it makes the distinction that you are searching for, which is the mechanism it discusses primarily used in diagnostic mammography that makes it more expensive is that the doctor is reading the film on site and then taking, as Doctor Dodd was saying, the next step to understand more about an abnormality.

In screening women are screened in volume and often their films are batched and read at once, so the need to be on-the-spot during all of the workups of each patient is eliminated, saving a lot of time and cost.

Chairman STARK. So your sense, Ms. Langer, is that at the $50 we are at least somewhere near the median cost, if not the high end of the high average cost of providing the screening tests?

Ms. LANGER. Well, really this report was quite welcomed because it is the first current large scale survey of costs that at least I have seen, but it did seem to indicate that in the $50 to $70 range there is a significant amount of effective diagnostic mammography activity occurring in the United States, and I would think that would be a goal for all of us.

Dr. DODD. I think the outstanding example of that is Dr. Richard Bird in North Carolina who has an extremely active screening program going for about 4 years now, and his charge has gradually increased from $27 to $32, and that is—

Chairman STARK. Would he like to bid on a nationwide program? He sounds like my kind of a guy.

Ms. LANGER. Fly Rich down.

Chairman STARK. Then I think it is fair that the two of you think the $50, while it might not be as generous as it ought to be, is a good start and will provide a meaningful benefit and is not just illusionary?

Dr. DODD. I would agree. In addition to the costs at the ACS we are really concerned about quality, and I would prefer to see that that be accentuated as long as the cost is not so small that no one will want to do it because they can't afford to do it.

Ms. LANGER. I think we have to remember the mechanics of assignment aside that $50 is still a significant incentive for a woman to know that the Government is participating in urging her and legislating that she participate in screening.

I guess I would like to take a moment to just comment on something Mr. Donnelly said about cost, which is that I understand what is happening in health care today and how very difficult it is to control, but if you are going to select one benefit to cover, Mr. Donnelly, I would suggest that the reason that this is a good one and probably pretty much unto itself in terms of precedent is that this is the most common form of cancer in American women, and it is a significantly responsive cancer to early detection.

It makes a tremendous difference if a woman has found her cancer early.

Chairman STARK. Thank you very much.

Mr. Chandler.

Mr. CHANDLER. Well, Mr. Chairman, I just would like to add that I appreciate your interest in the bill that Mr. Schulze and I introduced today.

My wife also has suffered breast cancer, and happily she is among those who had the disease detected early and has been well since 1977 without any reoccurrence, but the key was, as you so accurately point out, early detection.

She was a very young woman to have contracted the disease in her early thirties. And our bill also addresses colorectal, which again is a disease which with early detection treatment is more often successful. So, I think this is an area where we certainly need to be aggressive, and I agree with you that some participation, even if not ideal, is better than none at all.

And I just want to thank you for your testimony and your interest in our particular piece of legislation.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

Just so there will be no misunderstanding, I have no objection to the expansion of Medicare for this diagnostic benefit, and in many ways we should go well beyond mammograms and do many other diagnostic services because I think it is clearly proven just in terms of a physical basis, the quicker an illness is diagnosed, the cheaper it is in the long run.

The question comes, I guess, on a broader basis, just where is the Medicare system going? How should the Medicare system retrofit at age 65 with an individual's life-long working coverage? I think the repeal of catastrophic proved one point, that the system is not very well thought out and that it really needs to be revisited, both on a short term and on a long term basis, and that is why I ask the questions that I do.

Should the system be similar to the voluntary sort of system that the workers in this country have or should we maintain the mandatory nature of the system under the guise that the greater number of participants, the lower the costs and the greater the availability of services to all people regardless of their financial or economic status?

Let there be no misunderstanding about where I am coming from. My position will be as we go through this whole process of

adding additional benefits on a catch-as-catch-can basis, no matter how necessary and how beneficial that the questions have to be asked about who is going to pay, how is it going to be paid for, and what is the final end product of any expansion of the system.

I personally believe very strongly that the entire system has to be revisited and retrofitted to the 1990's, that it is a system that made a heck of a lot of sense in the 1960's, and in the 1970's, but makes less and less sense and becomes more irrelevant as we head into the 1990s.

The Medicare system basically hasn't changed since 1965, and if we are going to prevent reoccurrence of the objection that took place last year from the beneficiaries who we purport to help, then we need to really see how this system that covers 30-odd million beneficiaries at the age of 65 retrofits with the benefits that they have entering the system because both the male and female population—especially females—are entering the system in 1990 with a much different package of coverage than they did in the 1960's. So having said that, I really don't have any questions.

It is a great benefit, as are all of these benefits, and they seem to come at a very limited cost, but the next go around will be additional groups of people asking for additional and as necessary benefits most especially in the diagnostic area, an area that we should go in, and then the cost is going to be increased and increased, and I don't want to get into a situation where we were last year, so I sit here with one voice of caution.

I thank the gentleman for his time.

Chairman STARK. You didn't think we were going to try to sneak up on you, did you?

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Do either of you know what portion of medigap policies cover mammography?

Ms. LANGER. I don't know that. I was just asking that question.

Dr. DODD. I do not know.

Mrs. JOHNSON. Thank you.

Ms. LANGER. But I agree it seems very pertinent.

Mrs. JOHNSON. I think this kind of preventive care is very, very important. The compliant manner with which we accept 44,000 deaths is astounding.

After all, only 57,000 American service personnel died in the Vietnam war. To have that kind of death toll annually from a cause that we know early intervention and early identification can vastly change is irrational. I do think it is important to know how many policies currently cover this, whether they are used or not by women, and if not, why not, and what kind of reimbursement they provide.

So thank you.

Dr. DODD. There are about in excess of 20 States that have now passed——

Ms. LANGER. Twenty-six.

Dr. DODD. Twenty-six States have now passed laws requiring coverage of screening mammography by third party carriers.

Mrs. JOHNSON. Over what timeframe? Are these very recently passed or——

Dr. DODD. This has been over about the last 3 years.

Ms. LANGER. One of the problems actually is that we are now just starting to be able to ask for this data to understand what has happened as a result of these mandates, both as to compliance and, of course, to costs. We are just beginning to see the schedules which we need.

They are not yet available in any meaningful way. I will say, though, in your own studies you might examine the State of Maryland, which was the first State in the country to provide some sort of mandate which pertained only to medigap Medicare supplemental policies. I believe that was in 1986.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Speaking on behalf of the State of Maryland, I am very pleased that we did act on that. I recall the debate that took place and the overwhelming evidence that convinced us to move forward.

Although I don't share necessarily the conclusions that Mr. Donnelly reaches in looking at the expansion of the Medicare program, I do share his concerns for having the statistics before our committee as to how many people who are Medicare eligible are covered with some type of insurance protection for mammography testing and whether they, in fact, are using those benefits.

I take it that we don't have that information.

Dr. DODD. No.

Ms. LANGER. I don't have that information.

Mr. CARDIN. I think that would be helpful, Mr. Chairman, if we could try to get that information before us.

Thank you.

Chairman STARK. We will ask the staff to see if they can bring us up to date on that.

Mr. Levin.

Mr. LEVIN. Thank you. In response to Mrs. Johnson's very pertinent question, I think there are other data which would indicate that even where medigap policies cover mammography there would be an immense gap because the incidence of undetected breast cancer is higher as you go down the socioeconomic ladder, and I would think the medigap coverage is the same, so even if medigap policies provide coverage in half the States, there would still be an important vacuum here for Medicare to fill. And it seems to me that Medicare here should be proactive and our committee and subcommittee should encourage institutions of government really to promote detection. I don't think there is enough of that. I don't hear enough public service announcements urging people to use the benefits they have. I think that is also true of the private sector.

So let me just ask—maybe this is another fact that the staff will need to dig out if you are not familiar with it—do you know what the practice is in other countries regarding mammography? Canada and England and France and Japan? Any idea?

Dr. DODD. Insofar as the funding is concerned?

Mr. LEVIN. Whether women can obtain screening.

Dr. DODD. In Sweden that is a benefit that they are all eligible for and I believe also in Great Britain.

I can't tell you about the remainder.

Ms. LANGER. I might mention some interesting data—I would like to have the privilege of giving this to you in writing, but I learned last summer about programs in Finland where mammography screening is universally supplied, and they have something like a 93 percent compliance of women who follow screening guidelines in that country, and as you can imagine vastly reduced mortality rates from breast cancer.

Mr. LEVIN. And there has been a reduction in mortality from breast cancer?

Ms. LANGER. Yes.

Mr. LEVIN. Why don't we dig out those figures. It seems to me that they will help make this issue very much come alive.

I think all of us up here would join Mrs. Johnson in saying this is not an issue anymore germane to women than it is to men in terms of our responsibilities here.

Mr. DONNELLY. Will the gentleman yield?

Mr. LEVIN. Yes.

Mr. DONNELLY. I was very interested in the three countries you mentioned, Sweden, England and Finland. Do you agree with a national health system, something I strongly advocate to straighten out the mess we are in in health care availability and delivery to the American people?

I just wanted to state that for the record, that we are talking about a program here, Medicare, that specifically deals with a nonworking aged population.

I just want to point out the inadequacies and why we are running into a situation like this, because we have a health policy that didn't make much sense.

Mr. LEVIN. Well, I agree——

Mr. DONNELLY. It is of enormous cost and ineffective delivery. I will stop at that or we will be here until 7 o'clock tonight.

Mr. LEVIN. Right. But we have the opportunity to do something about part of the mess.

Mr. DONNELLY. Right.

Mr. LEVIN. I don't think that the overall situation should prevent a cure here. Thank you.

Ms. LANGER. Mr. Chairman, could I just make one remark. I think, of course, the national medicine program is a major factor, but I think it is clear from a couple of viewpoints that on breast cancer screening, women look for direction on screening.

We have many studies that show that women whose physicians suggest screening comply with guidelines at a very high rate. Well, now, you have also the opportunity to tell women what to do, much like the Governments of Finland and Sweden.

Chairman STARK. In my house that is a rare opportunity, too.

Ms. LANGER. And you can save some lives to boot.

Chairman STARK. Dr. Dodd, Ms. Langer, Thank you very much. I appreciate your taking the effort to participate with us today.

We would ask our second panel to come forward.

First we have Lovola Burgess, vice president of the AARP and Mary Gardiner Jones, secretary and member of the board of directors of the Older Women's League, affectionately known as OWL.

I want to welcome you both to the committee and ask that Mrs. Burgess proceed as she is first on the witness list and followed by Mrs. Jones.

Your prepared statement will appear in the record in its entirety. You can enlighten us or expand on your testimony in any manner with which you are comfortable.

STATEMENT OF LOVOLA BURGESS, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BURGESS. Thank you very much.

Good afternoon. My name is Lovola Burgess, I am from Albuquerque, New Mexico, and I am vice president of the American Association of Retired Persons.

First of all, I would like to say that I especially commend you, Chairman Stark, and the members of the subcommittee for your continuing interest in improving health care protection for older and disabled Americans.

I will center my remarks on three areas. First of all, the effect rising health care costs have had on older American's ability to obtain needed health care.

Second, the importance of the four new and expanded benefits included in H.R. 3880, and third, the financing of these benefits. To fully understand how important Medicare coverage of mammography screening, respite care, expanded home health care, and hospice care is, it is necessary to look at how increasing health care costs have widened the gaps in Medicare's protection of older beneficiaries. When it was created in 1965, Medicare dramatically increased access to acute health care services and reduced the out-of-pocket medical expenses for most elderly people, but over the years rising health care costs have gradually widened gaps in Medicare's protection.

Beneficiaries are faced with higher deductibles and coinsurance for services covered by Medicare as well as increased costs for necessary services not currently covered by the program. In many cases these costs have created financial barriers to essential medical services.

Coverage of preventive and long-term care services is a small but a very important step forward closing these gaps in Medicare. Each on of the beneficiaries include in H.R. 3880 is important to older Americans.

Let me briefly explain the reasons why. Breast cancer is the leading cause of cancer deaths among women today. One out of every nine women in American will develop breast cancer, and women 65 years of age and older are nearly twice as likely to develop the disease as younger women.

When diagnosed early, the chances for curing breast cancer are excellent and research has shown that mammography screening plays a key role in the early detection. Unfortunately, concern over the cost of the procedure coupled with lack of coverage under Medicare and other health care plans keep many older women from seeking this preventive service on a regular basis.

Medicare coverage of biennial mammography screening will greatly reduce one of the most significant barriers to this vital procedure.

A Medicare respite benefit, although very limited in nature, is an important step toward long-term care and is the type of support service that care givers most frequently want and need.

Right now fewer than one in five older Americans who need long-term care are in nursing homes. Most of these people remain in their communities and depend on family and friends for their care.

The burdens on those who provide informal, long-term care, both financial and emotional, are tremendous. The ability to take a needed break from care giving, secure in the knowledge that a loved one is well attended, will significantly reduce the burden of long-term care givers.

The expansion and clarification of Medicare home health care coverage is another important benefit. Current law limits the scope and accessibility of Medicare home health coverage.

This limitation has stemmed from both strict eligibility requirements and an inconsistency in the interpretation of the definition of intermittent care. This legislation helps to clarify the definition of intermittent care, and in doing so ensures that beneficiaries will now have greater access to the home care they most need.

Finally, the expansion of the Medicare hospice benefit beyond the current 210 day limit will ensure that terminally ill Medicare beneficiaries can continue without any interruption this unique from of care without loss of self-respect or dignity.

H.R. 3880 proposes to finance these new and expanded benefits though an increase in the monthly part B premium paid by beneficiaries, from 80 cents the first year to $1.30 over 5 years.

It will come as no surprise to you, Mr. Chairman, and to the other members of the committee, that given the road that we both have traveled these past few years, beneficiary-only financing is not what AARP would want to see used for future benefit expansion.

AARP views the traditional financing of Medicare part B which spreads the cost of the program across the entire population as a fundamental tenant of the Medicare program which should not be breached lightly. Any revenue shortfall which might occur as a result of such financing should be offset by income from such sources as increased tobacco taxes or inclusion of all State and local workers in Medicare.

The improvements to Medicare provided by this legislation are very important to older Americans and the response from our membership reinforces this.

However, as AARP weighs the importance of these benefits against concerns about beneficiaries ability to shoulder this increased financial burden now and in the future, it is our view that the premium-only financing is an extraordinary step that is acceptable only because the premium increase in this particular case is so small.

Should the cost of the benefits and the premium rise very much at all, Mr. Chairman, AARP would need to reevaluate its position on this delicate balance of benefits and financing.

In conclusion, I would like to say that AARP applauds your efforts to restore some critically important Medicare benefits. We appreciate the opportunity to share our views on this legislation and we look forward to continuing to work with you on improving the Medicare program.

Thank you.

[The statement of Ms. Burgess follows:]

STATEMENT OF LOVOLA BURGESS, AMERICAN ASSOCIATION OF RETIRED PERSONS, ALBUQUERQUE, NM

Introduction

Good afternoon. My name is Lovola Burgess and I am from Albuquerque, New Mexico. I am Vice President of the American Association of Retired Persons. I am pleased to be here this afternoon on behalf of AARP to discuss the Medicare Benefit Improvements Act. Before I begin, I would like to say that the Association commends you for your efforts to focus attention on the continuing need for coverage of preventive and long-term care services under Medicare.

I will center my remarks this morning on three areas: 1) the effect of rising health care costs on older American's ability to obtain needed health care; 2) the importance of the four new and expanded benefits included in H.R. 3880: mammography screening, respite care, expanded coverage of both home health care and hospice care; and 3) financing the benefits.

Rising Health Care Costs

To fully understand how important Medicare coverage of mammography screening, respite care, expanded home health care and hospice care is, it is necessary to look at how increasing health care costs have widened the gaps in Medicare's protection of older beneficiaries.

The Medicare program is the cornerstone of health care coverage for older Americans. Approximately 98 percent of the elderly are now covered by Part A - which is hospital insurance - and 97 percent pay the monthly premium for Part B coverage of physician and outpatient services.

When it was created in 1965, Medicare dramatically increased access to acute health care services and reduced out-of-pocket medical expenses for most elderly people. But over the years, the gaps in Medicare's protection have gradually widened. It is now estimated that older Americans spend about 15% of their yearly income on health care - roughly the same percentage they spent before Medicare was enacted.

Rising health care costs are largely responsible. In 1987, health care costs increased nearly ten percent over the preceding year. In 1988, price increases for hospital and physician services grew at roughly twice the rate of general inflation.

These cost increases have had a direct affect on Medicare beneficiaries. They are faced with increased deductibles and coinsurance for services covered by Medicare as well as higher costs for necessary services - like mammography screening - not currently covered by the program. It is estimated that for every dollar beneficiaries spend on Medicare deductibles and coinsurance, they spend another fifty cents to one dollar on non-covered services. In many cases, these escalating costs have created insurmountable financial barriers to essential medical services.

The expansion of Medicare to include important preventive and long-term care services is a small but important step toward closing the gaps in Medicare's protection of the elderly must be closed.

The Need for Coverage of Mammography Screening

Breast cancer is the leading cause of cancer deaths among women today. In 1989 alone, nearly 150,000 women -- 90 percent of them over the age of 50 -- developed breast cancer. Over 40,000 of these women died. Tragically, a third of these deaths could have

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been prevented by early detection.

One out of every nine women in America will develop breast cancer and older women are the most vulnerable. While there is still some question about the appropriate frequency of mammography screening for older women, we do know that women 65 years of age and older are nearly twice as likely to develop breast cancer as younger women. In light of this, the Association is pleased that H.R. 3880 provides that after 1993 the Secretary would have the discretion of revising the frequency of biennial coverage. At that time it will be important to carefully review the research findings in this area and to consider the implications for beneficiaries of any change in premiums that an expanded benefit might entail.

When diagnosed early, the chances for curing breast cancer are excellent - a 90% success rate - and research has shown that mammography screening plays a key role in this early detection. The Office of Technology Assessment has estimated that for the average 65 year-old woman, the probability of death from breast cancer is reduced nearly 20 percent with annual mammograms. Unfortunately, concern over the cost of the procedure coupled with lack of coverage under Medicare and other health care plans keep many older women from seeking this preventive service on a regular basis.

By providing Medicare coverage of biennial mammography screening, H.R. 3880 will greatly reduce one of the most significant barriers to this vital procedure. According to recent projections such coverage could save the lives of 4,000 Medicare beneficiaries each year.

The Need for Respite Care

The Association is pleased that H.R. 3880 restores the Medicare respite benefit. Although the benefit included in this legislation is limited in nature and will help substantially fewer beneficiaries than the respite care provision initially enacted into law, it is an important long-term care benefit and is the type of support service caregivers most frequently want and need.

Currently, among older Americans who need long-term care services, fewer than one in five receive this care in a nursing home. The remainder continue to live in their communities and depend on a network of informal caregivers - usually family and friends - for their care. Roughly three-quarters of disabled older persons who are not in nursing homes depend solely on this type of informal care.

The burdens on those who provide informal long-term care--both financial and emotional--are tremendous. One third of family caregivers are over the age of 65 themselves. Many live in or near poverty and describe their own health as relatively poor. Others, notably women, must balance the competing demands of their own families with their caregiving responsibilities. Almost one-half of adult daughters providing care to older parents are employed outside the home, and one-quarter have children under the age of 18.

Real life situations where the availability of respite care services could mean the difference between continuation of the in-home care an elderly beneficiary prefers and institutionalization best tell the story. There is the wife of the Alzheimers patient in Michigan who, by herself, has cared for her husband for the past five years rather than placing him in a nursing home; the 69 year-old woman in Alabama who is the sole caregiver for her 93 year-old mother; and the husband of an

Alzheimers patient in Maryland who has cared for his wife for the past thirteen years. For these three people, and thousands of others like them, the ability to take a needed break from their caregiving, secure in the knowledge that their loved one is well attended, will significantly reduce the burden of their caregiving responsibilities.

From a policy perspective, experience with an even small scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance--information which will be essential to the future development of a more comprehensive long-term care benefit.

It is the Association's hope that when a respite benefit is incorporated into a more comprehensive long-term care program eligibility criteria that more accurately reflect a need for long-term care will replace the criteria in this legislation. This will be important in ensuring that those Medicare beneficiaries with functional impairments--regardless of the cause--who most need this type of service are not precluded from coverage.

The Need for Expanded Home Health Care

The expansion and clarification of the Medicare home health benefit in H.R. 3880 is an important step toward simplifying Medicare. It will also ensure that the program provides a meaningful limited home health benefit.

Current law limits the scope and accessibility of Medicare home health coverage. This limitation has stemmed from both strict eligibility requirements and an inconsistency in the interpretation of the definition of intermittent care. While this legislation does not change the requirement that beneficiaries must require skilled care on an intermittent basis, must be under the care of a physician and meet the eligibility criteria, it does help to clarify the definition of intermittent care.

The Health Care Financing Administration has interpreted intermittent to mean four days or less per week. As a result, beneficiaries who meet the standard eligibility criteria and require skilled home health care less than four days a week have qualified for Medicare coverage. But individuals who need skilled home health care more than four days a week are often denied coverage.

H.R. 3880 expands the Medicare home health benefit by clarifying the definition of intermittent. Under this legislation an individual is defined as needing intermittent care if it is needed less than seven days a week. This means that beneficiaries could qualify for Medicare coverage of home health care if they met the standard eligibility criteria and required skilled care on an intermittent basis for up to six days a week. The legislation also provides that beneficiaries needing care seven days a week may be covered for thirty-eight consecutive days.

By expanding and clarifying the Medicare home health care benefit, beneficiaries will have now have greater access to the home care they most need.

The Need for Expanded Hospice Care

The Medicare hospice benefit has, for the past several years, provided terminally ill beneficiaries with a unique and valuable form of care unavailable in most other settings. The primary focus of hospice care is to ensure optimal comfort and enhance the quality of life for terminally ill beneficiaries and their

families.

In order to qualify for Medicare coverage of hospice care a physician must certify that the beneficiary has less than six months to live. After a beneficiary qualifies, Medicare currently covers only 210 days of hospice care. In the advent of new technologies and life-sustaining drugs, it is not uncommon for a terminally ill patient to live beyond the 210-day limit. Yet, in the case of Medicare, coverage of hospice care ceases after 210 days and the beneficiary or the hospice is then responsible for the remaining costs of his or her care.

Expansion of the 210-day limit will ensure that terminally ill Medicare beneficiaries can continue - without interruption - this unique form of care without loss of self-respect or dignity.

Financing

H.R. 3880 proposes to finance these new and expanded benefits through an increase in the monthly Part B premium paid by beneficiaries--from eighty cents the first year to $1.30 over five years. It is the intent of the bill to generate enough revenue to cover the estimated costs of the four new and expanded Medicare benefits.

It has long been the Association's policy that the federal budget deficit be brought under control so that our children and grandchildren are not left with an overwhelming financial debt. And from the standpoint that this legislation attempts to finance these needed Medicare benefits without adding to the federal deficit, you are to be commended. The Association is concerned however, about the unpredictability of health care costs and the affect that this continues to have on Medicare beneficiary out-of-pocket costs.

Currently, Medicare beneficiaries are required to pay twenty-five percent of Part B program costs. As health care costs have continued to escalate, this requirement has resulted in a substantial out-of-pocket burden for the elderly. In 1988, older Americans spent over $13 billion on Medicare's deductible and coinsurance requirements - up 180 percent from 1980. In 1988 Medicare beneficiaries also paid over $8 billion in Part B premiums. This was in addition to the over $16 billion paid for private supplemental insurance and the additional costs for needed services not covered by Medicare.

It should come as no surprise that, given the road that you and we have travelled over the last several years, beneficiary-only financing is not what AARP would want to see used for future benefit expansions. The Association views the traditional financing of Medicare Part B--which spreads the cost of the program across the entire population--as a fundamental tenant of the Medicare program which should not be breached lightly. Any revenue shortfall which might occur as a result of such financing should be offset by income from such sources as increased tobacco taxes or inclusion of all state and local workers in Medicare.

However, improvements to Medicare provided by this legislation are very important to older Americans and the response from our own membership reinforces this. The mammography benefit alone will mean the difference between life and death for 4,000 women each year.

As AARP weighs the importance of these benefits against concerns about Medicare beneficiaries' ability to shoulder this increased financial burden now and in the future, we view the premium-only financing in this Act as an extraordinary step that is acceptable only because the premium increase in this case is so small. Should the cost of the benefits in this Act--and therefore the premium--rise very much at all, the Association would need to

reevaluate its position on this delicate balance of benefits and financing.

Conclusion

In conclusion, I would like to say that AARP applauds your efforts to restore four critically important Medicare benefits. The current public policy debate over health care during the last several years has framed some new questions and challenges. While in some respects this nation's health care system is among the best in the world, many Americans--old and young--are not getting the kind of care they need when they need it. This is not made any easier by the fact that there is no way of knowing when a person is going to need a certain kind of care--whether it be physician or hospital services, preventive care, prescription drugs or long-term care.

What is clear, however, is that the rising costs of health care stands out as the most significant obstacle to obtaining affordable, appropriate and quality health care. We cannot address cost and the other shortcomings of our health care system in a piecemeal fashion. The real answers to these problems can only come if we view each of these concerns as part and parcel of a concerted effort to make health care--whatever its form--affordable and available to all Americans.

We appreciate the opportunity to share our views on H.R. 3880 and look forward to continuing to work with you on improving the Medicare program.

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Chairman STARK. Thank you very much, Ms. Burgess.
Ms. Jones.

STATEMENT OF MARY GARDINER JONES, SECRETARY AND MEMBER OF THE BOARD OF DIRECTORS, OLDER WOMEN'S LEAGUE

Ms. JONES. Thank you, Mr. Chairman.

OWL joins AARP in expressing its appreciation to this committee for bringing this bill on so promptly. OWL also shares the chairman's concern that the ultimate solution to these problems is going to be a comprehensive national health plan of some kind.

As the chairman and the committee know well, the problems you are dealing with are so urgent that they need to be acted on now even though the piecemeal approach is not one that any of us particularly like but it is critical that we do go forward on this. I will spend just a few minutes, Mr. Chairman, on some of the major points.

The witnesses before you have talked about the mammography screening. OWL also joins in endorsing all of their support for this highly critical important provision.

We estimate, I guess it is the chairman's statement that this bill will save almost 4,000 lives of women over 65 each year. We do have two thoughts and suggestions that we want to express on the mammography screening.

We have had some discussion here this afternoon on the question of whether the cap of $50 is too low, and the GAO report itself said that this is a brandnew field and they really don't have very much experience yet.

We suggest that perhaps a way for this committee to go would be to leave the cap where you have it but to provide in your legislation that after a year the GAO should make a study to see just exactly what experience there has been if we don't have the kind of response and there is evidence to suggest that laboratories simply are not offering it or doctors won't recommend it because they know that laboratories can't afford it, then perhaps this committee might want to take a second look. That might be a way for you to go on that issue.

The second issue that concerns the Older Women's League is the committee's provisions as it currently reads that women over 64 should only have a mammography screening every 2 years.

You have heard the testimony here this afternoon, the American Cancer Society has also confirmed this, that women over 65 are at special risk, 50 percent of the deaths, in fact, come from women over 65. Therefore it seems to us manifestly unfair and even discriminatory to say that women under 64 can have it every year but once you hit 64 you have to wait 2 years. That seems to us not quite logical in terms of what the evidence is.

The second point I want to comment on particularly is the home health services. Here we are particularly appreciative of this committee. We recognize that the home health services are minimal but nevertheless they are almost landmark in terms of what has gone on before, and we fully support and appreciate the committee having provided for this kind of home care.

Respite care the same way. Again, it is an essential that has been lacking in all health care, and we want to commend the committee and support your provision on it.

We do have one concern, however. In your draft you provided that respite care shall be for certain kinds of home care for certain kinds of activities of daily living, and you use the more traditional activities of toileting and bathing and what have you.

We want to bring to the committee's attention the fact that in Alzheimer's patients cases, their activities of daily living require supervision, not so much bathing and not so much toileting as the fact that they wander off, and we would like to work with you on some language that might change the ADL eligibility criteria so that we could cover the respite care for the Alzheimer's patient.

Fourth, on the hospice care, we just want to add our voice again to the other witnesses supporting the provisions that you have made here, which we recognize are essential, especially for older women. We are happy to see them in the bill.

I would like to make one comment, Mr. Donnelly, on the question that you raised on the choice of benefits and the whole volunteer program.

Obviously it is something that needs to be studied, but I would commend you the experience of the Federal Government, and I think of some businesses—but I am not so sure about that—where in offering a wide variety of choice to the Federal workers, what they discovered was that Federal workers with certain kinds of needs tended to flock to certain kinds of policies and what you did was you lost the actuarial basis of having enough people who might not have those conditions. That is a problem when you introduce what is frequently called competition, what you called choice, but it is a problem and in health care that one sometimes can destroy or distort the actuarial needs of the insurance company in order to be able to pay for it from people who are not appropriate to get that high risk.

I would just like to point that out to you.

Also I guess that Congressman Levin already made the point that the medigap insurance, to the extent that it covers mammograms, and I assume that the committee will be able to get some information on that, we would like to work with you and help you if we can, on tracking some of that information down, but I too want to point out that OWL's constituency are frequently lower middle income women, and they are the ones who are not appropriate to have medigap policies.

The medigap policies are appropriate to be the higher income women, the higher educated women, so when we have this problem of choice and duplication of benefits, it may be duplication of benefits for only certain income group people, and not for the people, for example, that OWL represents. So in conclusion, again, I want to repeat my gratitude and OWL's gratitude to all of you for the work that you are putting in on this bill, and to state to you that we want to work with you in any way we can to help you get this passed.

Thank you very much for permitting us to testify this afternoon.

[The statement of Ms. Jones follows:]

TESTIMONY OF MARY GARDINER JONES
OLDER WOMEN'S LEAGUE

Chairman Stark, distinguished members of the subcommittee. On behalf of the Older Women's League (OWL), I am pleased to testify today in support of H.R. 3880, the Medicare Benefit Improvements Act. For many years now, OWL has worked side-by-side with the Chairman to improve health insurance coverage for all Americans. As the Chairman well knows, the struggle has often been difficult and frustrating, and unfortunately, we still face a long road ahead.

OWL shares the Chairman's desire for a comprehensive health care plan that will provide adequate health insurance coverage for all, including coverage of long term care services. We know the Chairman has been diligently working through the Pepper Commission on just such a comprehensive approach to health care.

While the public and the Congress come to grips with how to finance universal health care coverage, swift passage of H.R. 3880 is needed to restore several important, even landmark, Medicare benefits that were needlessly sacrificed in the bloody battle over the Catastrophic law, a battle which saw no victors.

As key Members of Congress attempted to pull together a package to save some of the benefits provided under Catastrophic, the debate revolved around the big ticket provisions--the prescription drug benefit, the SNF benefit, the expanded hospitalization, and the cap on Part B costs. The benefits contained in H.R. 3880 seemed to be the gravy. Consensus existed on saving them and they could be easily added to any presentation of the more expensive entrees.

However, no deal was cooked up and the gravy, with nothing left to put it on top of, went down the drain with everything else.

All four of the benefits in H.R. 3880 would have, and should have, been in place this past January 1st. It has been projected that the mammogram screening provision alone would have saved an estimated 4,000 women's lives each year. Every month that we delay implementing this coverage some 333 women are dying from breast cancer who may have been saved. Since January 1st some 667 women's lives might have been spared.

The medical evidence is clear that mammogram screening saves lives. Half the states have now enacted state legislation requiring insurance carriers operating within the states to provide coverage for the screening. Surely, the federal government should be a leader, not a follower, in the provision of this coverage.

Speaking in crass dollars and cents terms, providing coverage for the small cost of the screening, saves millions, perhaps even billions, down the road in avoided costs from the expensive treatment of advanced breast cancer.

The elimination of the limit on hospice care would inject a small dose of rational humaneness to our otherwise piecemeal, helter-skelter health care delivery system. In cases where a doctor has certified that a patient is terminally ill, no arbitrary limit of coverage should exist for hospice care, particularly when the limit only serves to punish the hospice provider by having them swallow the costs beyond the Medicare limit and to provide more than a bit of indignity for a patient's final days.

Recognizing that Medicare's home health provision was not designed, and does not in practice, provide coverage for our nation's chronically ill in need of long term home health care coverage, we support the much-needed expansion of Medicare's coverage of intermittent home care services.

H.R. 3880 would extend the intermittent coverage from 21 consecutive days to 38. With so many beneficiaries being discharged quicker and sicker from hospitals under the Prospective Payment System and in need of intermittent skilled nursing care or physical or speech therapy in the home, this expansion will provide much assistance.

While the respite care provision for the chronically dependent in H.R. 3880 is very limited in both its length of coverage--80 hours per year--and its Part B out-of-pocket expense requirement ($1,780 in 1991), this provision would still represent the first time that Medicare has recognized the need to provide this type of support to family caregivers, three-quarters of whom are women.

We recently received a letter from a woman who had been caring for her chronically ill father for over five years. She wrote, "You can't imagine what it's like to not even be able to take a shower without worrying." Her simple words say it all.

In closing, while the Older Women's League will work for swift passage of H.R. 3880, and while we recognize the political expediency of maintaining the provisions in exactly the same form as they were in the Catastrophic law, we urge the subcommittee to adopt three important improvements.

First, the National Cancer Institute and ten major medical groups have recommended that women over age 50 should have a mammogram screening every year not every two years. We urge the subcommittee to extend coverage to women over 64 years of age for a screening annually rather than biennially. At a minimum, the legislation should provide women over 64 who are at high risk of developing breast cancer with annual coverage. Currently, the bill provides annual coverage to high risk women who are younger, but not to those over 64.

Secondly, the recently released GAO report on the cost of screening mammograms does not adequately answer the question of whether the $50 reimbursement limit in H.R. 3880 is so low that it will discourage some providers from offering the screening, thereby making the screenings less readily available.

The study concludes that low cost screenings do not compromise quality, however, the cost of a screening is dependent on the volume done. Most providers operate at relatively low volume, thereby making the average cost of a screening a little over $100 currently.

While it is true that public policy should encourage economies of scale and a more efficient system, we believe that a more comprehensive study must be completed after this provision has been the law for a year, to ensure that the low reimbursement level is not unduly hindering the availability and usage of the screening. We would urge an explicit provision in the bill calling for such a study.

Lastly, the language of the respite care provision should be clarified as to leave no doubt that victims of Alzheimer's Disease would qualify as "chronically dependent." We are sure that it would not be the Chairman's intent to exclude those persons who are among those most in need of respite care services.

As you are aware, with Alzheimer's the chronic dependence is based on cognitive impairment, not physical disability, until the very last stages of the disease. Caring for an Alzheimer patient is a never-ending task that creates enormous physical and emotional stress on the family member who is providing the care. Even a few hours of respite can make the difference in the caregiver's ability to keep going.

The language of the bill should clarify that "assistance" with the activities of daily living includes the help an Alzheimer patient needs--physical cueing, verbal reminding, and supervision. Additionally, the ADL eligibility criteria should include the need for supervision because of the inappropriate behaviors that create health and safety risks to the patient and to others.

We urge the subcommittee to adopt these changes and we pledge our continued support for swift passage of H.R. 3880.

We wish to include in the record a letter signed by a number of national women's groups in support of the mammogram screening provision.

September 29, 1989

Dear Representative:

As you consider changes to the Medicare Catastrophic Coverage Act (MCCA), we, the undersigned national women's organizations, want to underscore the importance of retaining the coverage of biennial mammogram screening, which is contained in the Stark-Gradison proposal.

Literally, your vote to maintain this important protection would save the lives of thousands of women.

The American Cancer Society reports that 42,000 women died in 1988 from breast cancer. Studies have shown that regular mammogram screening can prevent one-third of the deaths. Some 14,000 women's lives each year could be saved with regular screening--4,000 of whom are Medicare beneficiaries.

A mere two weeks ago, both First Lady Barbara Bush and Secretary Louis Sullivan publicly extolled the virtues of regular mammogram screening. More and more states are enacting laws to require insurance carriers within the state to such screening as a preventive measure. Now is not the time to take a major step backwards.

We urge you to ensure that the new mammogram screening coverage contained in the MCCA will remain a benefit under Medicare.

Sincerely,

Older Women's League
Church Women United
Displaced Homemakers Network
National Council of Jewish Women
National Women's Health Network
National Women's Law Center
National Women's Political Caucus
Women's Equity Action League
Women's Legal Defense Fund

Chairman STARK. Thank you both.

Ms. Jones, your concern is one shared by the Chair. I understand that we have asked GAO to look at definitional changes and how many people that might include.

You very quickly get into people suffering from mental illness who by this definition probably wouldn't be covered either, and it is a question then of whether we really know how quickly that runs the costs up.

Ms. JONES. Perhaps, Mr. Chairman, if I might interrupt for a minute. OWL has been endorsing a long term care policy, and it has some provision for Alzheimer's, but it simply allocates an amount of money that can be paid under the terms of the insurance policy to Alzheimer's patients.

Perhaps one could specifically mention Alzheimer's and say that they are entitled to whatever the respite care is.

Chairman STARK. Then we are going to have a list.

Ms. JONES. You have more experience with this than I have.

Chairman STARK. The debilitating effects of Alzheimer's and how widespread it is, there are a vast variety. I would say to you that our experience in expanding benefits has been far better on this committee than getting into ones started, and so I will just say that much and no more.

I would recognize Mr. Chandler, do you have any questions?

Mr. CHANDLER. No questions.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. I am assuming from both of your fine testimonies that you would be opposed to making these expanded benefits available on a voluntary basis?

Ms. JONES. I would be, sir.

Ms. BURGESS. As you know, we have been on record for some time against making new benefits voluntary. We see Medicare as a social insurance program and would prefer to keep it that way.

Mr. DONNELLY. Just so that I can understand AARP's position clearly, you would be willing to accept this package because the monthly fee is so low that in this case you would be willing to accept a sort of a beneficiary-only fee?

I am not trying to trick you into anything. We need to——

Ms. BURGESS. I know. I have addressed this question fully in our written testimony and hope your will review that. Let me try to summarize. At this stage we certainly feel that it should be looked at very carefully, and we know our people want those benefits because we have communicated with them.

However, the one area that is bothering us is whether or not costs will go up and then what would happen. You know the big problem still is health care costs, and that is where we have some problems with this type of thing.

We certainly are looking at it very carefully because it is a small——

Mr. DONNELLY. Well, like death and taxes, one thing is absolutely certain about the health care system in the United States, health care costs always go up.

Ms. BURGESS. I understand from looking at Bureau of Health Statistics information that even hospital rooms have gone up 10 percent, which surprised me. I didn't realize we still had that problem.

Mr. DONNELLY. It would be cheaper to stay in Trump Tower for a week.

I have one question about the whole issue of balance billing or mandatory assignment. This legislation, as you know, allows the physician to charge the beneficiary anything he or she wishes over that—up to 25 percent over the $50 reimbursement, except in the Commonwealth of Massachusetts where we had the good sense to prohibit that type of activity.

How do your organizations feel about this? You have expressed some concern that if you make it a voluntary program those beneficiaries of the lowest income would not opt into the program because that additional dollar per month is necessary for their daily living expenses, but on the other hand we are allowing a physician to charge an additional 25 percent, so now the fee could be as much as $62.50. Would you favor us prohibiting balanced billing, additional billing for mammogram services?

Ms. JONES. We have consistently supported that—prohibiting balanced billing—and would support it here, but on the other hand the benefit is so important and if in your wisdom you feel this is the way you are going to get it through, we are willing to go with it, but we have consistently supported prohibiting balanced billing.

Mr. DONNELLY. What is AARP's position on that?

Ms. BURGESS. We have been very concerned about balanced billing. We are hopeful that as the physician payment reform moves along that eventually that can be worked out to a much more satisfactory situation.

Mr. DONNELLY. Thank you very much.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

Just in regard to your last comments, I appreciate the fact that you have restrained yourself as an organization from supporting mandatory assignment.

If there is one lesson that Medicaid has taught us it is that if we mandate payments and prevent any other accommodation for cost, we will reduce access. Medicaid with its mandatory payments clearly indicates the human cost of that kind of policy. However, I believe that the variety of policies that this committee has supported will move us toward reasonable reimbursements that have some realistic relationship to cost of care and, therefore, will assure both cost control and access. I appreciate your leadership on this difficult issue.

The services that this bill does provide are extraordinarily important. In my State we have never seen a decline in medigap insurance costs no matter what happens with benefits, even under the catastrophic care bill. State mandates created increases in premiums even before we repealed the catastrophic care bill and staggering increases thereafter.

We need to examine how the private sector is dealing with these costs, whether they are bearing them, but it is a subject that both you and we need to know a great deal more about.

Ms. JONES. I understand there is a bill pending now before Congress, am I not right, that would require State insurance commissioners to regulate more strongly medigap insurance and require them to justify price increases?

Mrs. JOHNSON. In my State we do have fairly rigorous oversight of insurance premiums, and there are a lot of reasons why these costs are going up. Certainly in my State one of the big drivers of costs is mandated care and extension of mandates, and the Department of Aging documented that for us when this began happening, and really outlined for us how expansions of State mandates were going to prevent any reduction in medigap premiums in spite of the passage of catastrophic health care legislation. That was before we repealed it.

What they were basically saying is that the offset that we looked for when we passed catastrophic care was not going to take place in Connecticut because the State legislature had expanded the mandates on insurance carriers in the interim, so there is a very great concern in my mind about the relationship between promises and ability to deliver.

If we keep promising more and more and more and we are unable to deliver it, we do harm to those who need basic care and preventive care. At the same time we are unable to make good on our promises of expansive total care for research, so I do think the issue of insurance premiums and what drives them deserves a lot more attention than we have been able to give it.

I think the kinds of policies that our committee is pursuing will move physician reimbursements in the right direction, and I appreciate your support in trying to move rationally in that arena so that we don't damage access for seniors.

Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Ms. Burgess, I want to first compliment you on your testimony. It was extremely helpful to us.

I want to call your attention to page 10 of your statement that deals with AARP's opposition to beneficiary-only financing for future benefit expansion.

I certainly concur in your thoughts that the traditional financing of 25 percent of the cost being borne by the beneficiaries is what we should be looking at, but clearly if we are going to be able to move in this direction, this is the only avenue that is available this year.

I was wondering if you could share with us how AARP came to the conclusion that these benefits are worthy of moving forward at this time, even though it would be with the beneficiaries paying 100 percent of the cost?

Ms. BURGESS. We have talked to our members at various times, and during the catastrophic whatever you may call it, we found that our members really liked this part, that they really wanted those benefits.

They continue to like it. While we have not done extensive polling, we have sent out information to about 21,000 of our volunteers and have gotten back responses either by word of mouth, letters or in meetings.

They continue to feel that these benefits are very important and that they are needed, as you said, right now, and so we felt very strongly that we should certainly take a very careful look at this because those benefits are needed.

They are beginning to, in some ways, provide long-term care benefits which we see as a very, very crucial problem. This is at least a small beginning.

Mr. CARDIN. In your polling of your members have you discovered how many have this coverage through private medigap insurance?

Ms. BURGESS. Well, first of all, I would have to say I wouldn't consider it a real polling. It has been a very informal kind of thing in our working with our 21,000 volunteer leaders. Our research department is looking at that, and that was one of the questions I asked when I came into town from Albuquerque. They tell me that respite care is not available in private insurance. Also if your committee would like to have it, they are working on the remainder, and I can make sure that staff knows that you people would like to have what they find on the other three benefits.

Mr. CARDIN. I think that would be extremely helpful, and I would appreciate it if you would make that available to us. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. I have no questions. It has been excellent testimony, Mr. Chairman.

Chairman STARK. I want to thank the panel. I want to remind Ms. Jones that the Chair intends to introduce a bill shortly that will strengthen the Federal regulation of medigap insurance. We have a little problem now. We are not sure whether we will just apply the death penalty to the agent who sells duplicate coverage or to the agent and the head of the insurance company.

But once we resolve that, we will proceed to work on the bill.

Mr. DONNELLY. The State commissioners.

Chairman STARK. In States where the death penalty is legal. I thank the panel very much.

Our next panel includes representatives of home health care and hospice providers, Mrs. Frances L. Baby, cochair of the Government affairs committee and secretary of the association's board of directors. She is president of First Choice Home Health and Personal Services in Columbus, Ohio.

We are also pleased to welcome Mr. John J. Mahoney, the president of the National Hospice Organization.

Ms. Baby, you appear first on the list, so we will let you lead off. Your prepared testimony will appear in the record. If you would like to summarize or expand on your prepared testimony, please proceed.

STATEMENT OF FRANCES L. BABY, PRESIDENT, FIRST CHOICE HOME HEALTH AND PERSONAL SERVICES, INC., COLUMBUS OHIO; COCHAIR OF THE GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR HOME CARE; AND THE HOSPICE ASSOCIATION OF AMERICA

Ms. BABY. Thank you, Mr. Chairman and members of the committee. As you stated, my name is Fran Baby. I am currently serving as secretary to the board of the National Association for Home Care. I am also president of a home health care company in Columbus, Ohio.

The National Association for Home Care, which represents approximately 6,000 home health agencies and hospices across the country, as well as the millions of beneficiaries they serve, strongly supports the Medicare Benefits Improvement Act. We are very committed to assuring the availability of high quality home care services to all who require them.

The act provides much needed improvements to the home health and hospice programs. It will enable many disabled, chronically dependent and terminally ill beneficiaries to receive care in the comfort of their own homes. Home care is often a cost-effective alternative, as we have found out, to institutionalization.

It reinforces and supplements care provided by families, but most importantly encourages the independence of the individual and his family. What I have come to see in my 14 years in home care is a growing preference for home care by beneficiaries and their family members, and I guess now I am to the point that I receive daily reinforcement as to how popular that provision within the health care continuum is to our aged population 65 and over.

On a lighter note, I guess that reinforcement was made very evident to me last night when home health care was mentioned on the Alf program. My 7-year-old daughter was very impressed that in fact home health care was mentioned. I see home care as a very much preferred method of care. I really don't view it anymore as part of an alternative system, but just part of the continuum, and more and more I see patients who are directed toward home care services directly from the physicians' offices and totally bypass any sort of institutional care.

Of course, two provisions of your act, Mr. Chairman, that are very important to us are the extension of home health services and the in-home respite component. The extension of home health services will clarify what has now been an inconsistency in the application of the Medicare home health benefit by defining daily to mean care that is provided 7 days a week.

Currently there is a problem in that the Medicare eligibility criteria is not consistent with Medicare coverage criteria, and therefore 7 days, as the rest of us would define daily to be, is not 7 days consistently applied throughout the Medicare home health benefit. Those conflicting definitions, of course, have led to great confusion and a lack of access to beneficiaries for the home health care benefit.

Again, this provision would allow for consistent application of the home health care benefit and where eligibility is established, there would not be the problem that we do not currently have coverage available. In addition, the second element of that provision would allow up to 38 days of home health care.

We see this as a modest expansion of the home health care benefit, but one that would greatly benefit those patients who need daily wound care, have complicated discharges, post-hospital or who are post-technology ventilator dependent patients.

The other provision, the in-home respite services, is much needed and well-deserved. The respite care provision represents help to family and friends and care-givers of chronically ill beneficiaries. Among the chronically ill persons, only 20 percent are actually living in nursing homes right now.

Nearly three quarters of noninstitutionalized disabled elderly persons rely solely on care by friends and family. Only 5 percent receive all their care from paid sources. In addition, approximately 10 percent of those who we may call our older Americans have children who are also older Americans.

For the first time we have people who are called sandwich generation people and they have more parents living right now than children. We feel the fear that the family care-givers would be replaced totally by a paid respite care giver is totally unfounded.

I have to relate to you my experience from a hearing that resulted in expansion of home health benefits in Ohio. A witness, when confronted by a State legislature with regard to a respite benefit asked if, in fact, that care would be replaced, and I have to remember her response to that, which was when my husband feels well, I want to be with him, and when he is feeling bad, I can't stand to leave him.

I think that in a very short sentence summarizes the feelings of most beneficiaries with regard to the respite benefit. The third provision, relating to hospice, I am providing remarks on behalf of NAHC's affiliate, the Hospice Association of America. The key provision in this bill is that the 210-day lifetime limit for the Medicare hospice benefit would be eliminated. As you know, after the repeal of the catastrophic bill, hospice coverage reverted back to two periods of 90 days and one subsequent period of 30 days for a total of 210 days.

A hospice may not discharge or reduce services to a patient who lives beyond the mandated limit. While a hospice can seek reimbursement for these services from the patient, most patients are unable to pay and/or the patient is eligible for other Medicare benefits.

What is important to remember is that the Medicare hospice benefit was based on experience with cancer patients and predictions about the course of their illness can never be made with absolute certainty. There is also now a far greater degree of uncertainty for patients suffering from other terminal illnesses, such as heart disease, COPD, and ALS. Thus a hospice is faced with a very real risk that it will be responsible for continued care without having continued reimbursement.

Under current law a hospice must be very careful in accepting potentially high cost patients or risk putting the entire hospice program in jeopardy. As you all know, the hospice benefit does not change the cap that is currently in place.

In conclusion, the National Association for Home Care and its affiliate, the Hospice Association of America give their strong support to H.R. 3880. We are not only an association of providers, but I do feel that we do represent Medicare beneficiaries. Many times our professional staff are their only contact and the only way that they can get their information as to their needs is through our professional staff and then to people like myself who come before you.

I would like to, on behalf of NAHC representatives, thank you so much for your support in the past, and thank you for your introduction of this bill. I would also specially like to thank Representative Gradison, even though he is not here for his consistently

strong support of home care and hospice and to the beneficiaries they serve.

I will be very happy to answer any questions you have. Thank you.

[The statement of Ms. Baby follows:]

Statement of Frances L. Baby
on behalf of the

NATIONAL ASSOCIATION FOR HOME CARE

and

HOSPICE ASSOCIATION OF AMERICA

Testimony on
H.R. 3880
Medicare Benefits Improvement Act of 1990

Before the Subcommittee on Health
of the
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C.

February 27, 1990

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My name is Frances Baby. I serve as Co-Chair of the National Association for Home Care's (NAHC) Government Affairs Committee, as well as Secretary of the NAHC Board of Directors. I also serve as President of First Choice Home Health and Personal Services in Columbus, Ohio.

The National Association for Home Care, which represents approximately 6,000 home health agencies, homemaker-home health aide organizations and hospices, as well as the millions of beneficiaries they serve, strongly supports the Medicare Benefits Improvement Act of 1990, H.R. 3880. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

On behalf of the National Association for Home Care, I would like to take this opportunity to thank Chairman Stark and the Health Subcommittee Members for holding this very important hearing.

The Medicare Benefits Improvements Act of 1990 provides much-needed improvements to the home health and hospice programs that will enable many disabled, chronically dependent and terminally ill Medicare beneficiaries to receive care in the comfort of their own homes. Home care is a humane and often cost-effective alternative to institutionalization: It reinforces and supplements the care provided by family members and friends and encourages maximum independence of thought and functioning as well as the preservation of human dignity.

This bill, as introduced by Congressmen Pete Stark and Bill Gradison along with 51 original cosponsors, would expand and improve the Medicare program by restoring four very essential benefits that were lost with the repeal of the Medicare Catastrophic Coverage Act. Briefly, they are: (1) a home care provision to expand the Medicare home health benefit to cover daily (seven days a week) services for up to 38 days; (2) a respite care provision to allow up to 80 hours per year of respite care services to chronically dependent beneficiaries; (3) a hospice care provision to eliminate the 210-day lifetime limit for hospice services; and (4) a mammography provision to cover biennial screening for Medicare beneficiaries.

NAHC explores the first two provisions more thoroughly in the following pages, and its affiliate, the Hospice Association of America, comments on the third provision.

1. EXTENDING HOME HEALTH SERVICES

Section 4 of the Medicare Benefits Improvement Act contains two key elements that open the door to home care services for certain currently ineligible individuals. First, it would correct an inconsistency in the application of the Medicare home health benefit by defining "daily" care to mean care that is provided seven days a week. Second, it would allow for the provision of daily care for up to 38 days.

The first element of this provision would clarify the definition of "daily" care in eligibility criteria and make it consistent with coverage criteria. Current Medicare eligibility criteria defines "daily" care as care that is needed for five, six or seven days a week, whereas coverage criteria defines "daily" care as care needed seven days a week. These conflicting definitions have led to great confusion and an inconsistent application of the home health benefit.

A recent Federal Court decision (Duggan vs. Bowen, also known as the "Staggers" lawsuit) clarified the definition of "daily" for purposes of coverage as seven days a week, but was silent on the definition of daily with respect to eligibility because Congress had clarified this definition in the Medicare Catastrophic Coverage Act of 1988 (MCCA). The repeal of the MCCA then left two inconsistent definitions of the term "daily." H.R. 3880 would restore the definition lost with the MCCA repeal to correct the current inconsistencies.

The second element, the provision of daily (seven-day-a-week) care for up to 38 days, would represent a modest expansion of the home care benefit. Currently, patients who need daily care (five, six or seven days a week) for an indefinite period of time do not qualify for any coverage. H.R. 3880 would allow those patients to receive coverage of daily care for up to 38 days.

Examples of individuals in this group would include those who have non-healing wounds or who are technology-dependent, such as ventilator patients. Although this population is small, H.R. 3880's proposed allowance for 38 days of care would provide an opportunity for a transition into home care supported by private insurance and other programs, a postponement of potential institutionalization and an opportunity to remain at home with family and friends during the last stages of a patient's life.

Although NAHC unreservedly supports this section which expands the home care benefit, it encourages the Committee to consider strengthening the proposal by increasing the length of time that beneficiaries could receive daily home care. H.R. 3880 recommends that the limit be set at 38 days. NAHC's members have indicated that 62 days, which is the current Medicare certification period, would be more appropriate.

2. IN-HOME RESPITE CARE FOR CHRONICALLY DEPENDENT INDIVIDUALS

Section 3 of H.R. 3880 would expand the Medicare benefit to include coverage -- for the first time ever -- of respite care services for chronically dependent beneficiaries. This benefit is essential to caregivers whose efforts make it possible for severely impaired beneficiaries to remain in their homes and avoid institutionalization.

This respite care provision represents much-needed and well-deserved help to friends and family caregivers of chronically ill beneficiaries. Among aged chronically ill persons, only 20% live in nursing homes; the remainder continue to live in the community primarily because of the unpaid assistance of family, friends and neighbors. Nearly three-quarters of noninstitutionalized disabled elderly persons rely solely on care by friends and family; only 5% receive all of their care from paid sources. Persons providing such caregiving are burdened by many responsibilities and demands associated with providing long-term care to a disabled relative or friend. Such problems include limitations on one's personal life, the competing demands of financial obligations and work conflicts, the care recipient's emotional and physical demands, as well as emotional, financial and family strains.

H.R. 3880 would allow up to 80 hours a year for in-home care (including homemaker-home health aide services and licensed nursing care) for chronically dependent individuals. Individuals would be eligible to receive these services for 12 months after they first meet an out-of-pocket Part B deductible ($1,780 in 1991) through copayments. A "chronically dependent" individual would be defined as an individual who is dependent on a voluntary caregiver for daily assistance with at least two activities of daily living (eating, bathing, dressing, toileting or transferring in and out of bed or in and out of a chair).

In the past, there has been some reluctance to create a respite care benefit for fear that it would replace family caregiving. However, studies show this fear that families will withdraw their help if services are made available is largely unfounded. Furthermore, researchers found little evidence that policies aimed at providing formal services to caregivers and care recipients encouraged caregivers to substitute paid care for care by family and friends. Available data indicate that most families purchase services only when the responsibility of care becomes too great for them to handle or when they become exhausted. Respite care can keep a beneficiary from entering a nursing home.

Again, NAHC fully supports this provision, but invites the Committee to consider two revisions. First, NAHC would support more hours of coverage per year. Second, NAHC believes no deductible should be required.

3. EXPANSION OF HOSPICE BENEFIT

I am providing the following comments on the hospice provision of the bill on behalf of NAHC's affiliate, the Hospice Association of America (HAA).

HAA is a professional organization representing over 1,200 hospices and their caregivers who provide service to thousands of terminally ill Americans from across the country. HAA is grateful for the opportunity to offer its support for the provision of the bill which would reinstate the "fourth" benefit period for Medicare hospice beneficiaries. With the repeal of the Medicare Catastrophic Coverage Act in 1989, the lifetime limit for the Medicare hospice benefit was restored. As a result, hospice coverage is now limited to two periods of 90 days and one subsequent period of 30 days over a beneficiary's lifetime --- a total of 210-days.

A hospice may not discharge or reduce services to a patient who lives beyond the mandated limit. While a hospice can seek reimbursement for these services from the patient, most patients are unable to pay.

The Medicare hospice benefit and its 210-day lifetime limit was based on experience with cancer patients and predictions about the remaining life span of cancer patients can generally be made with a degree of accuracy. However, there is a far greater degree of uncertainty for many other terminal patients who can benefit from hospice care. These patients suffer from such terminal illnesses as heart disease, chronic obstructive pulmonary disease (COPD) and amyotrophic lateral sclerosis (ALS). Thus, where these noncancer terminal patients are concerned, a hospice is faced with a very real risk that it will be responsible for continued care without continued reimbursement.

For example, a hospice in Iowa had a COPD patient who had lived six months beyond the 210-day limit at a cost to the hospice of $14,000. This same hospice cared for an ALS patient who lived two months beyond the 210-day limit at a direct services cost of $660 per month, a figure which does not include drugs, durable medical equipment or overhead. These are only two examples, but they illustrate why, under current law, a hospice must be very careful in accepting potentially high-cost patients or risk putting the entire hospice program in jeopardy. This situation not only places hospices at risk, but can limit the access of terminally ill patients to the Medicare hospice benefit.

Subjecting hospices and their patients to the macabre task of counting down days of eligibility runs counter to the intent of the creation of the Medicare hospice benefit -- to provide more humane care to America's terminally ill in the comfort of their own homes.

4. CONCLUSION

NAHC and HAA give their strong support to H.R. 3880, and would be pleased to offer their assistance to the Committee in its endeavors regarding this bill.

The much needed benefit improvements contained in H.R. 3880 would go a long way toward enabling many disabled, chronically dependent and terminally ill Medicare beneficiaries to receive care in the comfort of their own homes.

Again, Mr. Chairman, and Members of the Subcommittee, thank you for the opportunity to present our testimony today. I will be happy to answer any questions you may have.

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Chairman STARK. Thank you very much. Mr. Mahoney, I am going to suggest to you if you can summarize in about 5 minutes—we have three votes coming at about 5 minutes to the hour, and that will take us about half an hour, and I would hate to keep you waiting while we do that. So we could probably wrap up if you want to summarize your prepared testimony for us. Thank you very much.

STATEMENT OF JOHN J. MAHONEY, PRESIDENT, NATIONAL HOSPICE ORGANIZATION, ARLINGTON, VIRGINIA

Mr. MAHONEY. I will do my very best.

In the first quarter of every year NHO conducts a census of hospices in the United States. We are collecting data now for 1989. Our survey for the last year suggests that there were 1,405 hospice programs across the country and at least another 269 programs under development.

About 800 hospices are now Medicare certified or have applied for Medicare certification as a hospice. In preparation for this testimony NHO distributed a special questionnaire to our Medicare certified members to assess the effect of the unlimited fourth benefit period during 1989.

The results of that survey indicate that in 1989, 88 percent of all Medicare certified hospices served a patient who exceeded 210 benefit days. In 1988, 3.2 percent of hospice Medicare patients exceeded 210 benefit days, increasing to about 4 percent in 1989.

In 1988, the average length of stay for those patients exceeding 210 benefit days was 300 days, increasing to approximately 308 days in 1989. The results appear to confirm NHO's prediction that the benefit period would not be used by very many beneficiaries, but that those individuals that do use the expanded benefit appear to have a significant need.

The survey results also suggest that the average length of stay in hospice of all Medicare patients lengthened, possibly because referring physicians were less concerned about their patients running out of benefits. Hospices feel that the fourth unlimited benefit period should be restored because many physicians are again reluctant to refer a patient to the hospice program because they are concerned that their prognosis of the patient's condition will not be precisely accurate.

To compensate for this concern, the physician often refers the patient to the hospice program when the patient has only days and sometimes hours to live. One of the consequences of these late referrals is that the patient and family are denied the very services that they may need at the most vulnerable time of their lives.

In a recent report by the General Accounting Office, it was noted that many of the non-Medicare certified hospices are concerned that the expense of one extraordinarily costly patient could force them into bankruptcy. While the hospice may bill patients after Medicare hospice benefits are exhausted, hospices may not discharge patients because of their inability to pay.

NHO very strongly endorses this principle. However, most of the noncertified programs in the country are small, and the reinstate-

ment of the fourth benefit period would remedy a significant risk for them associated with participating in Medicare.

This act also does not eliminate the need for a 6-month prognosis to be eligible for the benefit, nor does it eliminate the overall aggregate reimbursement cap. These restrictions appear to be sufficient to maintain this benefit exclusively for the terminally ill.

The NHO membership also supports other provisions of H.R. 3880. While perhaps technically available to hospice patients, in-home respite care is not separately reimbursed and therefore not a practical alternative that many hospice programs can offer.

The availability of home respite care would be of significant assistance to the family care-giver. As I am certain the subcommittee can appreciate, caring for a terminally ill loved one is a physically and emotionally exhausting experience. NHO therefore requests that hospices be added as providers of in-home respite care and that hospice patients not be required to waive these new benefits if they are added to the Medicare program.

The NHO membership would also like to voice its support of the screening mammography benefits of H.R. 3880. Those of us who work with the terminally ill in hospice know first hand how critically important prevention and early detection is in fighting cancer.

A significant percentage of hospice patients die of breast cancer. With early detection most of these patients could have avoided hospice care for many years.

I would like to conclude my remarks by thanking the subcommittee for inviting us to testify in front of them today. I would like to thank the members of the subcommittee, particularly Mr. Stark and Mr. Gradison, for their support of hospice care over the last 8 years. With your help hospice programs have changed how our nation cares for the terminally ill.

We have given them back control over their lives. We have given them the dignity they deserve, and we have allowed them the opportunity to live as they choose to live until they die.

Thank you.

[The statement of Mr. Mahoney follows:]

National Hospice Organization

TESTIMONY OF JOHN J. MAHONEY
PRESIDENT OF THE
NATIONAL HOSPICE ORGANIZATION
BEFORE
THE HOUSE WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

FEBRUARY 27, 1990

On behalf of the National Hospice Organization, I would like to thank the Subcommittee for inviting the NHO to testify in support of H.R. 3880, the "Medicare Benefit Improvements Act of 1990." Specifically, I would like to speak in support of Section 5, Expansion of Hospice Benefit. This section would eliminate the 210-day limit on Medicare hospice benefits by reinstating a fourth unlimited benefit period which was eliminated with the repeal of the Medicare Catastrophic Coverage Act of 1988. I would also like to voice our membership's support for additional sections of H.R. 3880.

The National Hospice Organization (NHO) is a non-profit membership organization headquartered in Arlington, Virginia. Established in 1978, NHO is dedicated to advocating quality care for terminally ill people and their families. NHO's membership currently includes more than 1000 hospices and about 1800 hospice professionals. NHO provides educational programs, technical assistance, publications, advocacy, and a national referral service.

In the first quarter of every year, NHO conducts a "census" of hospices in the United States. We are collecting data now for 1989. Our survey for last year suggests that there were 1405 hospice programs across the country, and at least another 269 programs were under development or were providing fewer services than necessary to be considered as a hospice as defined by the NHO Standards of Care.

A review of NHO census data suggests the following information about hospice care in the United States:

* Thirty-nine percent of all hospices are independent organizations.

* Thirty percent of all hospices are hospital based.

* Twenty-two percent of all hospices are home health agency based.

* Ninety-five percent of all hospices are non-profit or governmental entities.

* The average hospice served 171 patient/families in 1988.

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* Hospices served 102,000 patients on the Medicare Hospice Benefit.

NHO estimates about 800 hospices are now Medicare certified or have applied for Medicare certification as a hospice from the Health Care Financing Administration.

As you know, the Medicare Catastrophic Coverage Act of 1988 lifted the original 210-day limit on Medicare hospice benefits by adding a fourth unlimited benefit period, effective January 1, 1989. In preparation for this testimony NHO distributed a special questionnaire to our Medicare certified members to assess the effect of the unlimited fourth benefit period during 1989. The results of that survey indicate:

* In 1989 88 percent of all Medicare certified hospices served a patient who exceeded 210 benefit days.

* In 1988 3.2 percent of hospice Medicare patients exceeded 210 benefit days.

* In 1989 4.2 percent of hospice Medicare patients exceeded 210 benefit days.

* In 1988 the average length of stay for those patients exceeding 210 benefit days was 300 days.

* In 1989 the average length of stay for those patients exceeding 210 benefit days was 308 days.

* In 1988 the average length of stay for all hospice Medicare patients was 48 days.

* In 1989 the average length of stay for all hospice Medicare patients was 54 days.

While I would not want to suggest that this survey could or should be considered scientific research the results appear to confirm NHO's prediction that the benefit period would not be used by very many beneficiaries, but that those individuals that do use the expanded benefit appear to have a significant need. The survey results also suggest that the average length of stay in hospice of all Medicare patients lengthened, possibly because referring physicians were less concerned about their patients "running out" of benefits.

As part of our recent survey we also asked our membership what NHO should say to this Subcommittee regarding H.R. 3880.

Obviously our membership supports elimination of the 210 day limit on hospice care under the Medicare Hospice Benefit. Our membership feels that the fourth unlimited benefit period should be restored because:

1. Many physicians are again reluctant to refer a patient to the hospice program because they are concerned that their prognosis of the patient's condition will not be precisely accurate.

This concerns many physicians because they do not want to put their patients or the hospice program at financial risk. To compensate for this concern, the physician often refers the patient to the hospice program when the patient has only days and sometimes hours to live. One of the consequences of these late referrals is that the patient and family are denied the very services they may need at the most vulnerable time of their lives.

2. Another consequence of the 210 day cap is that when the hospice benefits expire, the consumer once again becomes eligible for traditional Medicare coverage for services related to the terminal illness. This means that the patient may also receive services from non hospice providers, and in some instances may be billed for these services. We believe the hospice does as good a job as possible in mitigating these problems for the patient, but it can be very confusing for the patient/family at a time when they are easily confused, and concerned with more important issues in their lives.

3. In a recent report by the General Accounting Office it was noted that many of the non-Medicare certified hospices are concerned that the expense of one extraordinarily costly patient could force them into bankruptcy. While the hospice may bill patients after Medicare hospice benefits are exhausted hospices may not discharge patients because of their inability to pay. NHO strongly endorses this principle. Most of the non-certified programs in the country are small however, and the reinstatement of the fourth benefit period would remedy a significant risk for them associated with participating in Medicare.

4. Care for the terminally ill is most costly in the last weeks of life. Consequently, the limitation on this benefit puts the patient back into the traditional Medicare reimbursement system. Since outpatient drugs and continuous care home nursing are not covered under regular Medicare benefits this creates an expense that the patient/family may have to absorb.

5. This Act does not eliminate the need for a six month prognosis to be eligible for the benefit, nor does it eliminate the overall aggregate reimbursement cap. These restrictions appear to be sufficient to maintain this benefit exclusively for the terminally ill.

The NHO membership also supports other provisions of H.R.3080. While perhaps technically available to hospice patients, in-home respite care is not a practical alternative that hospice programs can offer. Inpatient respite care is paid for (at an inadequate reimbursement rate), but no separate payment is made for home respite care. It is covered by the routine home care rate which now averages $75.00 per day.

The availability of home respite care would be of significant assistance to the family caregiver. As I am certain the Subcommittee can appreciate, caring for a terminally ill loved one is a physically and emotionally exhausting experience. An uninterrupted night of rest, an afternoon away from home with friends, a period of quiet time without the responsibility of providing care can allow the caregiver an opportunity to rejuvenate themselves and to go on providing care in the home when the alternative may be care in the hospital or nursing home. NHO therefore requests that hospices be added as providers of in home respite care and that hospice patients not be required to waive these new benefits if they are added to the Medicare program.

The NHO membership would also like to voice its support of the screening mammography benefits of H.R. 3880. Those of us who work with the terminally ill in hospice know first hand how critically important prevention and early detection is in fighting cancer. A significant percentage of hospice patients die of breast cancer. With early detection, most of these patients could have avoided hospice care for many years.

I cannot tell you with any authority what the cost impact of mammography screenings will be to the Medicare system. I can tell you the impact of the screenings at a personal level. Twenty-six years ago my mother was diagnosed with cancer through the use of a mammography screening. She is very much alive today and is now retired having completed a career as a Registered Nurse and mother of three children.

I would also like to conclude by thanking the members of this Subcommittee, particularly Mr. Stark and Mr. Gradison for their support of hospice care over the last eight years. With your help, hospice programs have changed how our nation cares for the terminally ill. We have given them back control over their own lives; we have given them the dignity they deserve, and we have allowed them the opportunity to live, as they choose to live, until they die.

National Hospice Organization - 1901 N. Moore Street - Arlington, VA 22209 - (703) 243-5900

Chairman STARK. Thank you both. It is my hope that we will expand these benefits. Your interest in the past as now is appreciated and will be helpful for us in presenting this bill to our colleagues on the committee for markup.

We hope we will get it to the floor this year for early consideration, and your taking the time to be here is of great assistance.

Thank you both very much.

[Whereupon, at 3:50 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF NANCY LOMBARDO, Ph.D
CHAIR, PUBLIC POLICY COMMITTEE
VICE-CHAIR OF THE BOARD OF DIRECTORS
OF THE ALZHEIMER'S ASSOCIATION

Mr. Chairman and Members of the Subcommittee, on behalf of the Alzheimer's Association, I want to raise serious concerns about H.R. 3880 which, among other things, would provide respite services to certain chronically dependent individuals under the Medicare program.

The Alzheimer's Association is the national voluntary agency dedicated to research for the prevention, cure and treatment of Alzheimer's Disease and related disorders and to providing support and assistance to afflicted patients and their families. We work through 207 chapters, over 1600 support groups, and 30,000 volunteers in every part of the country. It is on their behalf that we submit this statement to the Subcommittee and request that it be made a part of the Record of your hearing on the legislation.

Overview of Our Concerns and Recommendations

Respite care is an issue of the highest priority for our Association. It is an immediate and pressing need for the women and men who today are bearing the day-in day-out burden of caring for a loved one afflicted with Alzheimer's Disease or a related disorder.

Unfortunately, H.R. 3880 as introduced would provide little if any assistance for these families because:

1. The eligibility criteria exclude most Alzheimer patients and others whose chronic dependence is based on cognitive impairment, and

2. The requirement for very high out-of-pocket medical expenses discriminates against Alzheimer patients and others who have high expenses associated with their need for chronic care, but limited medical bills because there is no medical treatment or cure for the disease.

We urge you, at a minimum, to clarify and expand the definition of chronically dependent individual to include the cognitively impaired. This essential concept has already been accepted by the House in the Medicaid frail elderly amendments the House passed last year and by the Pepper Commission in its recommendations for long-term care. It would be a tragic step backward for this Committee to advance legislation that knowingly excludes the very families who are among those most in need of the services the bill would offer.

We also recommend that you reduce or eliminate the requirement for high medical expenses as quickly as it is fiscally possible to do so.

Caring for An Alzheimer Patient Is an Unending Task Which Places Enormous Physical and Emotional Stress on the Caregiver

Alzheimer's is a degenerative and irreversible disease that steals a person's mind and robs him or her of the ability to do even the simplest tasks. Often the patient remains physically capable until the latest stages of the disease. He or she simply forgets how and when to eat, to bathe, to dress. Someone has to be there to provide verbal reminders and physical cues, to break the task into manageable parts, and to supervise the patient's performance.

Because Alzheimer's destroys memory, judgment, and reason, someone also has to be there to protect the patient from behavior that endangers his health and safety or that of others. If left alone, a patient may wander away from the house and forget where he is. She may light a gas burner or turn on the iron, and then forget all about it.

A dementia patient often has difficulty following directions or communicating wants and needs. Most cannot use a telephone for help. Some hallucinate, become combative or depressed. The patient is "chronically dependent" in every sense of the word, but would not meet the test established in H.R.3880.

As Alzheimer's progresses, the patient eventually loses all physical functions and is eventually rendered incontinent, mute, uncommunicative, immobile and completely helpless. At that time, he or she would meet the eligibility test in H.R. 3880, but the respite services may come too late to help the family.

Seventy to eighty percent of Alzheimer patients remain at home, where family members overwhelmingly provide the care. Many caregivers are elderly spouses who are themselves in fair or poor health, or adult children with responsibilities for care of their own young children as well as their frail elderly parents.

The Advisory Panel on Alzheimer's Disease found that "[c]are of the demented patient is perhaps the most difficult form of family help, produces the most caregiver strain, interferes most with caregivers' employment, and has the most negative effects on family lifestyle and relationships." Caregiving takes its physical toll as well. Recent NIMH studies have demonstrated that caring for an Alzheimer patient has measurable negative effects on the caregiver's immune and cardiovascular systems.

Caring for a family member with dementia is a constant and demanding task. And it goes on and on. My own mother has had Alzheimer's Disease for 24 years. Families who watch their loved ones gradually disappear, losing all that has made them a person, describe their experience as "an endless funeral."

That is why respite care is so essential. The chance to get away, even for just a little while, can make the difference in a family member's ability to continue as the primary caregiver, and to keep the loved one at home.

The Association has taken the lead in the effort to expand respite services in this country. We are funding directly, and in cooperation with the Robert Wood Johnson Foundation, several dozen respite care programs in local communities. Our chapters have been instrumental in developing other respite programs with their own funds and through state and local agencies. These efforts have demonstrated both the need for and the value of respite for family caregivers, but they cannot begin to meet the demand.

H.R.3880 Would Provide Little If Any Benefit for Alzheimer Families

According to the Commonwealth Fund Commission on Elderly People Living Alone, "caring for the cognitively impaired may in fact take a greater toll on caregivers" than caring for the physically impaired. Yet H.R. 3880 appears to exclude most of them: first, through an overly narrow definition of "chronically dependent individual", and second, by requiring high out-of-pocket medical expenses.

We recognize the budget constraints under which the Subcommittee is operating. However, we believe it would be possible to make several changes to H.R. 3880 which would open the door to services for Alzheimer and related disorders families, and others caring for loved ones with similar cognitive impairments, while keeping the cost of the program under control.

A. Definition of "chronically dependent individual".
H.R. 3880 limits eligibility for respite services to individuals who are "chronically dependent" because they need assistance in order to perform at least two Activities of Daily Living (ADLs). Eligibility based on an ADL test, if it is limited to need based on a physical impairment or to "hands on" assistance, will exclude all but the most severely impaired Alzheimer patients (many of whom may have reached the point where institutionalization has become unavoidable, whether or not respite is available).

Even if the ADL test is interpreted to include the types of assistance with ADLs that Alzheimer patients need, the bill still would exclude an estimated 10 to 20 percent of Alzheimer patients who can perform most if not all ADLs by themselves but who are so cognitively impaired they cannot be left alone without creating serious health or safety risks to themselves or others. Their caregivers need respite every bit as much as those whose family members would meet an ADL test.

We recommend two changes in the definition of "chronically dependent individual" on page 14 of H.R. 3880. The first would simply clarify the proposed language of the bill with regard to ADLs. The second would expand the definition.

1. We recommend that "assistance" in the performance of activities of daily living be clarified to include the types of assistance needed by persons with Alzheimer's Disease or related disorders, and by those similarly cognitively impaired. This can be accomplished by adding the phrase "(including verbal reminding, physical cueing, or supervision)" after the term "assistance" on line 10, page 14.

   Subsection (kk)(2)(B) of Section 1861 of the Social Security Act, as amended by Section 3 of H.R.3880, would then read as follows:

   "(B) without such assistance (including verbal reminding, physical cueing, or supervision) could not perform such activities of daily living."

2. We recommend that the definition of "chronically dependent" be expanded to include those who need supervision because their cognitive impairment causes problem behaviors that pose serious health or safety hazards to themselves or to others. This can be accomplished by adding the following language after (B) as modified above:

   "or, (C) because of cognitive impairment, requires substantial supervision on a daily basis because he or she engages in inappropriate behaviors that pose serious health or safety hazards to self or others."

These two changes build on eligibility language the House has already accepted in the Medicaid Frail Elderly Community Care Amendments which were part of the House version of the Omnibus Budget Reconciliation Act last session (and which have been reintroduced as H.R. 3933 this year). These same principles are embodied in many of the long-term care proposals which have been introduced in the past two years and in the recommendations of the Pepper Commission.

It would be a tragic step backward for Congress now to enact a Medicare respite bill -- one small piece of a long-term care system -- that knowingly ignores this group of frail elderly most in need of such services.

B. Requirement for high out-of-pocket part B cost-sharing. The changes in definitions we propose above would assure coverage of the cognitively impaired. By themselves, however, they will not assure services, because relatively few of the potentially eligible families will be able to meet the requirement for high out-of-pocket part B cost-sharing.

We believe this cost-sharing requirement may exclude many of the physically impaired whose full time caregivers need respite. We know it will exclude a very large number of dementia patients, even though spouses and adult children are providing round-the-clock care. The reality is that most people with Alzheimer Disease or related disorders do not have high medical expenses, unless they have acute medical problems in addition to their dementia.

This does not mean that Alzheimer families can readily pay for respite care. In fact, the typical family does have high costs associated with the disease, but they are not part B costs. For example, Mrs. M., who is in her early 60s, is the primary caregiver for her husband who has had Alzheimer's for 18 years. She spends over $2000 a year on nondurable supplies for the care of her incontinent husband -- none of them reimbursable under Medicare.

Another very major cost for Alzheimer and related disorders families is the lost wages of the spouse who retires early or the adult child who leaves a job to become a full time caregiver.

Service providers and support groups who work with Alzheimer families report that families caring for a patient at home are reluctant to spend money for services in the community, including respite care, because they are saving funds for what they see as the inevitable time when they will have to place their loved one in a nursing home. That will not change until major long-term care legislation is enacted.

By requiring high out-of-pocket part B cost-sharing, Congress will be limiting the respite benefit to people who are very sick. While this may be an appropriate way to ration some Medicare benefits, in the case of respite it may have the effect of shifting the benefit away from those for whom it is intended -- the chronically dependent.

If Congress is truly interested in a meaningful Medicare respite benefit, available to those caregivers of both physically and cognitively impaired family members who need it most, then the requirement for out-of-pocket expenses must be lowered or eliminated as soon as it is fiscally possible to do so.

* * * *

We would like to raise one final issue for the record, although we realize this may be beyond the scope of the Committee's consideration at this time. H.R. 3880 would provide one important
element of respite care -- services in the home, which will offer critical relief for the families who are eligible for the services.

There are other types of respite care, provided outside the home, that may be equally or even more important and necessary in some family situations. These include adult day care and occasional overnight services outside the home. There are any number of successful models of the full range of respite services, including a number of the projects supported by the Association and our chapters. We hope it will be possible to move toward a more complete package of respite services in the near future.

The Alzheimer's Association appreciates the opportunity to comment on this important piece of legislation. We hope that it will be modified sufficiently so that the Association can lend its support to its enactment. We are available to work with you toward that end.

STATEMENT OF JOHN R. JARRETT, M.D., PRESIDENT, AMERICAN SOCIETY OF PLASTIC & RECONSTRUCTIVE SURGEONS, BEFORE THE HOUSE WAYS & MEANS COMMITTEE HEARING ON H.R.3880, THE MEDICARE IMPROVEMENTS BENEFIT ACT OF 1990.

The American Society of Plastic and Reconstructive Surgeons (ASPRS) is strongly supportive of legislation to restore biennial mammography screening to those benefits covered by Medicare.

Many of the other witnesses have made the strong case for a cost-benefit ratio, from an economic perspective, that favors reinstatement of coverage. Indeed this is a very crucial consideration during a period of constrained spending and budget deficits. Also important to us, as surgeons, however, is the efficiency of a complete and properly-administered mammography screening. A compelling statistic is cited by the American Cancer Society: survival rates in excess of 90% can be achieved when the disease is detected in a subclinical stage. It is for this reason that ASPRS has said on more than one occasion that this is one weapon in the war on cancer that must not be discarded in the name of economy and budget cutting.

Plastic and reconstructive surgeons have working experience with the ravages of cancer and the human toll that this disease exacts. We urge the committee to make mammography screening as broadly available as possible and believe that coverage by Medicare is an important component of that access. We commend the Committee for its interest and urge your support for restoring these benefits to Medicare recipients.

STATEMENT BY CONGRESSMAN HAROLD FORD

HEARING ON THE MEDICARE BENEFIT IMPROVEMENTS ACT OF 1990

FEBRUARY 27, 1990

Mr. Chairman, I would like to thank you for the opportunity to submit my statement into the Record.

Last year, the Members of Congress did something that millions of senior citizens had hoped we would not, and we never heard their voices. We repealed the Medicare Catastrophic Coverage Act of 1988. By doing this, we eliminated a host of benefits that are crucial to the lives of our senior citizens, a segment of our society that is growing at a phenomenal rate.

As you know, approximately twelve (12) percent of Americans are over the age of 65. By the year 2020, one (1) out of five (5) Americans will be senior citizens. We should welcome this change, not fear it. The combination of medical improvements and demographics have helped more Americans live for a longer time.

But just as we should not fear this change, nor should we ignore it. If older Americans are to enjoy a standard of living that they deserve, we must make some changes in our health care provisions. Long-term care should not be a luxury awarded to a few Americans who can afford such insurance; currently, less than two (2) percent of elderly Americans have private insurance for long-term care. The price of long-term care insurance is cost-prohibitive for the majority of Americans. And our health care system should not encourage senior citizens to pay for nursing home and hospital care, when they can get the care that they need at a less expensive price.

In addition, older women must be able to have mammography screenings in order to detect breast cancer as early as possible. We have the methods to save thousands of women from unnecessarily passing away; we should employ them. The availability of mammography screenings is also fiscally responsible. Either we can pay for a test and early treatment, or we can pay for more expensive cancer treatments, hospital charges, and a number of other costs further down the line.

I signed on as an original cosponsor of the Medicare Benefit Improvements Act of 1990 because this bill provides mammography screening and long-term care benefits that no elderly American should be without, and it does so at a modest cost. Mr. Stark and Mr. Gradison deserve to be congratulated for producing this important and responsible legislation, and for their commitment to the health of elderly Americans. I am proud to join them today as one Member of Congress who is committed to ensuring that older Americans get the care they need, and I look forward to the early passage of the Medicare Benefit Improvements Act of 1990.

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA—UAW

OWEN F. BIEBER, PRESIDENT BILL CASSTEVENS, SECRETARY-TREASURER

VICE PRESIDENTS

ODESSA KOMER • ERNEST LOFTON • STAN MARSHALL • STEPHEN P. YOKICH

IN REPLY REFER TO
1757 N STREET, N.W.
WASHINGTON, D.C. 20036
TELEPHONE: (202) 828-8500
FAX (202) 293-3457
TELEX 710-822-1941

March 6, 1990

The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

This statement is being submitted by the UAW in connection with the hearing conducted by the Subcommittee on Health on February 27 concerning the proposed Medicare Benefit Improvements Act of 1990 (H.R. 3880). We would appreciate it if you would include this statement in the record of the hearing.

The proposed legislation would basically expand Medicare to cover a limited set of benefits: i.e., mammography screening, expanded home health and hospice services, and in-home respite care. These benefits had been included in the Medicare Catastrophic Coverage Act, but were eliminated when that Act was repealed.

The UAW agrees that these benefits are extremely valuable. We therefore support efforts to expand Medicare to cover these services.

But we have reservations about the method of financing these benefits which is specified in H.R. 3880. Under the bill, the benefit improvements would be paid for entirely through an increase in the flat Part B premium which is paid by all Medicare beneficiaries. Although the increase in the Part B premium would not be large, we are concerned that this approach would violate the social insurance principles which have formed the basis for financing Medicare.

As a matter of basic philosophy, the UAW rejects the notion that any improvements in Medicare should be financed entirely by the beneficiaries of that program. Senior citizens rebelled against the Medicare Catastrophic Coverage Act precisely because it placed the entire burden of financing catastrophic benefits on the elderly. We are concerned that the financing mechanism in H.R. 3880 could cause a similar reaction.

Accordingly, the UAW urges the Subcommittee on Health to explore alternative means of financing the important benefit improvements contained in H.R. 3880. The UAW is prepared to work with you, Mr. Chairman, and the other Members of the Subcommittee on this difficult issue.

Your consideration of our views on this important legislation will be appreciated. Thank you.

Sincerely,

Dick Warden

Dick Warden
Legislative Director

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